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# Governor's Council on Substance Abuse Report

## Recommendations for State Policy Action during the 2003-2005 Biennium

**Priscilla Lisicich, Ph.D, Council Chair**  
**Carol A. Owens, Ed.D, Staff Coordinator**

**June 2002**

Washington State Department of  
Community, Trade and Economic Development

**Martha Choe, Director**

# **Governor's Council on Substance Abuse**

## **Mission, Vision and Values**

### **Council Mission Statement**

It is the mission of the Governor's Council on Substance Abuse to recommend public policy to promote healthy, safe and drug-free communities in Washington State.

### **Council Vision Statement**

The Governor's Council is a model for proactive, cross-system collaboration, working with all public and private sector stakeholders, Councils and other organizations to present a balanced approach for the prevention, treatment and law and justice efforts to reduce substance abuse in Washington State.

### **Council Value Statements**

The Governor's Council on Substance Abuse will

- ♦ advocate for the education, involvement and empowerment of Washington's citizens to act locally to reduce the misuse and abuse of alcohol, tobacco and other drugs.
- ♦ trust and honor the knowledge, strengths and cultures that make each Washington community unique.
- ♦ develop balanced and accountable prevention, treatment and law and justice strategies to reduce the misuse and abuse of alcohol, tobacco and other drugs.
- ♦ recommend substance abuse reduction strategies for programs, systems and organization built on science-based approaches.
- ♦ ensure the results of Council research and recommendations are available and accessible as a resource for efforts to reduce substance abuse in Washington State.

***(Amended January 2002)***



Office of Community Development

*Providing financial and technical resources to build livable and sustainable communities.*

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**Carol A. Owens, Ed.D, Staff Coordinator**

**June 2002**

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*For more information, please contact the Governor's Council on Substance Abuse at 360-725-3039 or 725-3034.*

*Additional copies of this and other Council reports can be obtained by calling the Washington State Alcohol/Drug Abuse Clearinghouse at 1-800-662-9111, or by writing them at 3700 Rainier Avenue South, Suite A, Seattle, WA 98144. Council reports are also available at [www.ocd.wa.gov/factsheets/local/drugfree.htm](http://www.ocd.wa.gov/factsheets/local/drugfree.htm) or from the Washington State Library. For a list of Council reports see Appendix D*





STATE OF WASHINGTON

OFFICE OF COMMUNITY DEVELOPMENT

906 Columbia St. SW • PO Box 48350 • Olympia, Washington 98504-8300 • (360) 725-2800

July 1, 2002

The Honorable Gary Locke  
Governor, State of Washington  
Legislative Building  
Post Office Box 40002  
Olympia, Washington 98504-0002

Dear Governor Locke:

On behalf of the Governor's Council on Substance Abuse I am pleased to forward our State policy and program action recommendations for the 2003-05 Biennium.

During 2001, the Council held community access meetings in Tacoma, Moses Lake, and Clarkston to enhance the Council's knowledge of how substance abuse is impacting local communities. The Council also conducted a workshop at the annual statewide prevention summit. During this workshop youth from across the state shared with the Council their views on the substance abuse issues in Washington State.

A collaborative, cross-system approach is reflected throughout the 2003-05 recommendations of the Governor's Council on Substance Abuse. All of the policy papers presented in the report were researched and written by staff from multiple agencies and community stakeholders who had specific interest and expertise in the topic areas presented. The following is a list of substance abuse topics researched and presented here in a policy paper format that includes an issue analysis and recommendations for 2003-05 state policy and program action.

1. Cross-System Collaboration for Substance Abuse Programs
2. Chemical Dependency Treatment Capacity
3. Child Welfare Services for Drug-affected Families
4. The Cross-System Methamphetamine Strategy
5. Reducing Underage Drinking
6. Marijuana: The Knowledge Risks and Enforcement of Current Laws
7. Eliminating Exposure to Secondhand Tobacco Smoke
8. Interagency Narcotics Taskforces as One Strategy to Reduce Drug Trafficking

The Honorable Gary Locke  
July 1, 2002  
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We hope these recommendations will be of assistance to you in developing substance abuse reduction policy for the 2003-05 Biennium. Please contact me or Council staff if you would like additional information about these recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read "Priscilla Lisicich", with a stylized flourish at the end.

Priscilla Lisicich, Ph.D.  
Chair  
Governor's Council on Substance Abuse

Cc: Dick VanWagenen, Governor's Executive Policy Office  
Marty Brown, Director of Office of Financial Management  
Martha Choe, Director of the Department of Community,  
Trade and Economic Development  
Sung Yang, Acting Director of the Office of Community Development

# ACKNOWLEDGMENTS

The Governor's Council on Substance Abuse wishes to acknowledge the generous assistance provided by organizations and individuals who collected information, conducted background research and drafted the policy papers that make up this report. The Council would like to recognize the following for their contributions of time, effort and expertise:

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**The points of view or opinions contained in this document do not necessarily represent the official position of the Governor's Office, the Department of Community, Trade and Economic Development, or other participating agencies.**

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## **EXECUTIVE SUMMARY**

The Governor's Council on Substance Abuse was created by governor's executive order in 1994 to respond to the significant human, social and economic costs that substance abuse inflicts on individuals, families, and communities throughout Washington State. Council membership includes private industry, local and tribal government, treatment providers, community groups, educators and law enforcement. State government is represented on the Council by the directors of the seven state agencies providing substance abuse programs and one legislator from each caucus of the House and Senate.

The Council carries out this mission by:

- Studying the causes of substance abuse.
- Identifying alternatives for state policy actions that protect Washington's residents from the spread of substance abuse impacts.
- Recommending policy program actions to assist communities to create healthy, drug abuse-free social environments for our children and families.

The Council strives to provide common, statewide strategies that balance prevention, treatment, and law and justice efforts.

There are eight policy papers presented in this report recommending state policy and program action during the 2003-05 biennium. Each paper provides an issue analysis and specific recommendations to the Governor and state agencies. The topic areas covered in this report include the following:

1. Cross-System Collaboration for Substance Abuse Programs
2. Chemical Dependency Treatment Capacity
3. Child Welfare Services for Drug-affected Families
4. The Cross-System Methamphetamine Strategy
5. Reducing Underage Drinking
6. Marijuana: The Knowledge Risks and Enforcement of Current Laws
7. Eliminating Exposure to Secondhand Tobacco Smoke
8. Interagency Narcotics Taskforces as One Strategy to Reduce Drug Trafficking

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# **INTRODUCTION TO 2003-05 POLICY RECOMMENDATIONS OF THE GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE**

The Governor's Council on Substance Abuse was created by governor's executive order in 1994 to respond to the significant human, social and economic costs that substance abuse inflicts on individuals, families, and communities throughout Washington State.

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The Council carries out this mission by:

- studying the causes of substance abuse
- identifying alternatives for state policy actions that protect Washington's residents from the spread of substance abuse impacts
- recommending policy action to assist communities to create healthy, drug abuse-free social environments for our children and families.

The Governor's Council on Substance Abuse strives to provide common, statewide strategies that balance prevention, treatment, and law and justice efforts. It is the Council's philosophy that creating a drug abuse-free social environment for our communities is like building a three-legged stool with prevention, treatment, and law and justice efforts each representing one leg of the stool.

The philosophy of Washington's Governor's Council on Substance Abuse is consistent with the national direction outlined in the President's National Drug Control Policy. Noting several ways treatment and law enforcement work in tandem, the National Drug Control Strategy points out that drug treatment reduces crime and shrinks the market for illegal drugs; law enforcement helps direct substance abusers toward treatment and can provide leverage which makes treatment mandatory. According to the strategy report, "A clearer example of symbiosis is hard to find in public policy." (Office of President, 2002.)

## **Current Facts about the Impact of Substance Abuse in Washington State**

As part of its research the Council heard from researchers and substance abuse prevention, treatment and law and justice practitioners about the gains and the remaining challenges for reducing substance abuse and its impacts. The following are some current facts about the impact of substance abuse in Washington State.

- Washington State's total economic burden in 1996 from drug and alcohol abuse and addiction was \$2.54 billion, or roughly \$531 per non-institutionalized state resident. For each dollar the state collected in alcohol tax revenue during fiscal year 1996, \$12 was spent as a result of alcohol abuse. (T.M. Wickizer, 1999.)
- About one in ten of Washington's adults in 1998 needed treatment for substance abuse or addiction. Statewide that same year, public funds were enough to provide treatment to only one-fifth (18.3%) of those eligible for publicly funded services. (Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2001.)

*Research reveals that for every public dollar invested in alcohol / drug treatment, \$3.71 is saved in medical care and criminal justice costs alone, over the following four years.*

*Department of Social and Health Services,  
Division of Alcohol and Substance Abuse, 2001*

- Nearly one-quarter (22 percent) of Washington State's 8th grade students responding to the Survey of Adolescent Health Behaviors during 1999-2000 reported using alcohol during the past 30 days. More than one in ten said they had smoked marijuana (12.0%). One-third of high school sophomores (37.6%) and almost half of seniors (46.8%) reported alcohol use during the same time period, while about one in five Grade 10 students and one in four Grade 12 students said that they used marijuana during the previous month (RMC Research Corporation, 2001.)
- Almost one in four (24%) of Washington's adults smoke tobacco – and 29% of seniors in high school. Twelve is the average age at which people living in Washington start smoking.
- Tobacco use causes 90 percent of deaths from chronic lung disease and lung cancer, 45 percent of heart disease deaths in people younger than 65, one-third of all cancer deaths, and one in ten deaths of newborns. In 1997, one death in five in Washington was due to a tobacco-related illness. (Washington State Department of Health 2001.)
- Some 4 out of 5 (82 percent) youths committed to Washington Juvenile Rehabilitation Administration are substance abusers or are chemically dependent.

*"Groups of middle school students with low involvement in substance use and violence/delinquency scored an average of 53 points higher on math, 24 points higher on reading, and 53 points higher on writing on the 1999 Washington Assessment of Student Learning (WASL) than groups with moderate involvement, defined as 1-2 violent or delinquent acts in the past year, or having tried alcohol or drugs in the past month"*

*Mandell, Dorothy J. et. al.*

- Between 56 percent and 79 percent of adult arrestees (depending on geographic location) in Washington State need substance abuse treatment, according to a 1997 study. (Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.)
- A number of studies in Washington State, and nationally, reveal that chemical dependency treatment is associated with subsequent reductions in crime, arrests, and jail time for both youth and adults. For example, a study of 450 chemically dependent youth in Washington State revealed that felony arrests decreased more than 50 percent between the year before and the year after treatment. Misdemeanor arrests decreased 40-plus percent. Washington State arrests of all adults in outpatient treatment during 1997 dropped from 61 percent in the year before treatment to 8 percent during treatment. (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2000.)
- Six months after treatment, 79.5 percent of adults who, before treatment, were considered indigent, unemployable, and incapacitated due to addiction reported they had been abstinent for the past three months. 39.7 percent had been employed full-time during the past three months, and 21.9 percent part-time. (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse 2001.)
- Youth prevention is key to reducing substance use and abuse. A recent Washington Kids Count research report warns that “the 2000 Washington State Survey of Adolescent Health Behaviors . . . [reveals] that 20 to 40 percent of Washington middle school and high school students reported the kinds of attitudes and behaviors [related to substance use and violence] that our analyses linked to impaired school performance. (Mandell 2002.)

### **Process for Development of 2003-05 Recommendations for Substance Abuse Policy and Program Action**

During 2001, the Governor's Council on Substance Abuse held community access meetings in Tacoma, Moses Lake, and Clarkston to enhance the Council's knowledge of how substance abuse is impacting local communities. The Council also conducted a workshop at the annual statewide prevention summit. During this workshop, youth from across the state shared their views on the substance abuse issues in Washington State.

During 2001, the Council also reviewed and updated its own statements of Vision, Mission, and Goals first developed in 1994 to better reflect the impacts and needs for a common approach to reducing substance abuse. These are included on the back cover and the inside front cover of this report.

Since 1994, the Council has seen an increasing need to build collaborative approaches to create stronger connections among substance abuse prevention, treatment, and law & justice agencies at the state and local level.

*"We have to fight drug abuse on all fronts—prevention, treatment, and law enforcement . . . Nothing threatens the future of our state's children more than drug use."*

*Gary Locke  
Governor*

The Council sees this collaborative approach as essential if efforts to reduce substance abuse and its impacts are to succeed in Washington State.

This collaborative, cross-system approach is reflected throughout the 2003-05 recommendations of the Governor's Council on Substance Abuse. All of the policy papers presented in the report were researched and written by staff from multiple agencies and community stakeholders who had specific interest and expertise in the topic areas presented.

Many of the 2003-05 recommendations cut across prevention, treatment, and law & justice, demonstrating the cross-system interaction necessary to effectively control the supply and reduce the demand for alcohol, tobacco, and other drugs. Substance abuse impacts every corner of our communities. Cross-system efforts must recognize what our law enforcement agencies need to keep our neighborhoods safe from drug-related crime. We must actively support prevention strategies to reduce future abuse. We must provide treatment for Washington citizens whose lives have already been disrupted by substance abuse. We must also welcome other partners such as public health and ecology that are simultaneously working on other substance abuse impacts.

### **Development of 2003-05 Recommendations and Policy Study Papers**

In Washington State substance abuse prevention programs are provided through a collaborative process that organizes the efforts of many organizations and individuals to provide lasting change in communities to reduce and prevent the impact of substance abuse.

"Prevention is a proactive process that empowers individuals and communities to meet the challenges of life events and transition by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

Prevention requires multiple processes which involve people in a proactive effort to protect, enhance, and restore the health and well being of individuals and their communities. It is based on the understanding that there are factors that vary among individuals, age group, ethnic groups, and risk-level groups...prevention strategies include:

- Universal Services designed to reach the entire population.
- Select Services targeted to at-risk or under-served populations.
- Indicated Services for individuals identified as experiencing early signs of substance abuse. (Department of Social and Health Services, Division of Alcohol and Substance Abuse 2002).

The research-based risk and protective factor model for substance abuse prevention provides a framework that is used by most of the state-funded substance abuse prevention efforts. Some communities also use this model in conjunction with youth asset-building and resiliency-based models. The planning process in local communities uses data linked to specific risk factors identify the factors that put youth at greatest risk for becoming substance abusers. The prevention strategies based on the risks identified by each community are designed to buffer or protect youth from these risks. To accomplish this prevention services provide youth with opportunities to participate in their community, help to develop the skills they need for successful participation and by recognition for their participation.

The definition for prevention which is quoted above comes from a soon to be released State Substance Abuse Prevention Plan for the State of Washington. This plan was developed over a 3-year period through a State Incentive Grant (SIG) from the Center for Substance Abuse Prevention. The process for developing this plan involved the collaborative work of many state, local agencies, and community stakeholders. An advisory group for the SIG grant was co-chaired by the Governor's Council on Substance Abuse and the Division of Alcohol and Substance Abuse's Citizen Advisory Council. This Committee had representation from all state and local groups with an interest in providing the most effective system for prevention. The result is seven objectives for change and development of our state's prevention system that have been agreed to by all the participants in this planning process:

1. Selection of overarching desired outcomes and measures.
2. Development of a centralized and uniform data collection system.
3. Adoption of prevention program criteria.
4. Development of a uniform reporting mechanism.
5. Options for state agencies to coordinate, leverage and redirect money and resources.
6. Establishment of opportunities for professional development.
7. Evaluation of prevention strategies developed through the state incentive grant.

The State Incentive Grant will end June 30, 2002, but development of these seven objectives will continue. To assist in this effort the Governor's Council on Substance Abuse has agreed to host a Prevention Standing Committee with representatives from the state and local stakeholders who will develop this work. The agencies involved in the Washington Interagency Network Against Substance Abuse (WIN) will continue to work together to develop the processes necessary to implement these goals, and will provide periodic progress reports to the Prevention Standing Committee and the Governor's Council.

The Prevention Standing Committee will function as a permanent work group to research and develop prevention and issues for the Governor's Council on Substance Abuse. The first task of the Committee, which was implemented in February of 2002, was to develop the Prevention Recommendations presented in this report. The Committee is also working with data identified through the SIG process as key indicators of the progress Washington State is making in its efforts to prevent substance abuse. The Governor's Council will release the Committee's work in early 2003 as Washington's first Report Card on Prevention.

The Prevention Standing Committee's first set of substance abuse prevention issues focus on three of the issues related to preventing the abuse of alcohol, tobacco, and other drugs the Committee believes are feasible to accomplish during the 2003-05 Biennium. Those issues are 1) underage drinking; 2) marijuana; and 3) second-hand smoke.

## **Introduction of 2003-05 Recommendations and Policy Study Papers**

The policy papers that follow this section present issue analysis and recommendations for 2003-05 policy and program action in eight areas.

The Governor's Council on Substance Abuse recommends the following state policy and program action for 2003-05:

### 1. Cross-System Collaboration

- Cross-system coordination for Chemical Dependency Treatment services.
- Use of research-based models in prevention, treatment and law and justice programs.
- Cross-system chemical dependency training for professional staff from other fields who work with drug-affected clients.

*"It seems like someone else's life when I think back to how insane my life was until I went to treatment. Come March I will have 12 years clean and sober . . . in a few months I will have my Master's degree, and last year I bought a house! . . . I try to give back . . ."*

*Ramie and Family*

### 2. Chemical Dependency Treatment

- Increase chemical dependency services for low-income adults and youth from 22.6 percent to 40 percent of the estimated need.
- Revision of Washington Basic Health Plan's chemical dependency treatment benefit to be consistent with other group health benefit plans.

### 3. Services for Drug-affected Families in the Child Welfare System

Includes recommendations that DSHS Children's Administration take the following action:

- Analyze prevalence and impact of substance abuse of the Child Welfare System.
- Improve cross-agency collaboration with the Division of Alcohol and Substance Abuse.
- Review and strengthen policies and protocols for work with clients with substance abuse issues.
- Review current substance abuse training provided to caseworkers to determine its adequacy for dealing with increased numbers of drug-related families.
- As vacancies occur, recruit at least one child welfare worker with professional chemical dependency training for each DCFS office.

### 4. Continue a Coordinated, Cross-System Strategy for Dealing with Methamphetamine Impacts

- Continue cross-system coordination through the Governor's Meth Coordinating Committee.
- Expand training and technical assistance for local, community-based meth action teams.
- Implement statewide protocols for dealing with drug endangered children found at lab sites.
- During 2003, revise and update the Council's 2000 Methamphetamine report.n

## 5. Reduce Underage Drinking

- Improve the statewide enforcement and monitoring of alcohol retail outlets.
- Provide retail training on the zero tolerance law for selling or providing alcohol to minors.
- Restrict alcohol advertising at public locations such as sports and community events, outside of convenience stores, and on billboards.
- Consider a higher tax on alcoholic beverages.
- Educate the public, especially parents, about the risks of underage drinking.

*"I struggled through 17 years of addiction that began at age 13, with alcohol, amphetamines and marijuana. I dropped out of high school in my freshman year. . .The most important part of my story is the effect of my recovery on my daughter. Today she is 25 years old, working full time, enrolled in college and working on a Ph.D."*

*Cindy*

## 6. Increase Knowledge of the Risks Associated with the Use of Marijuana and Enforce Marijuana Laws

- Implement the Washington State Prevention Plan as official state policy.
- Clarify and enforce laws related to access and use of marijuana.
- Improve enforcement of RCW 69.20.102 prohibiting the sale or possession of drug paraphernalia.

## 7. Secondhand Smoke

- Eliminate secondhand smoke exposure for children.
- Eliminate preemption to state laws to allow local jurisdictions to enact stronger environmental tobacco smoke restrictions.
- Eliminate secondhand smoke exposure in the workplace.

*"I got sober from a little nudge from the judge. Fortunately, as a first time offender, I was offered treatment instead of jail time. . .Today my 12 year-old daughter and I have security, reliable transportation, and a bright future."*

*Deborah*

## 8. Narcotics Taskforces

- Review the current funding formula and model for narcotics taskforces through a work group of members of the Washington Association of Sheriffs and Police Chiefs.
- Provide recommendations to the Department of Community, Trade and Economic Development for use in developing Byrne Grant budget proposals to the Governor.

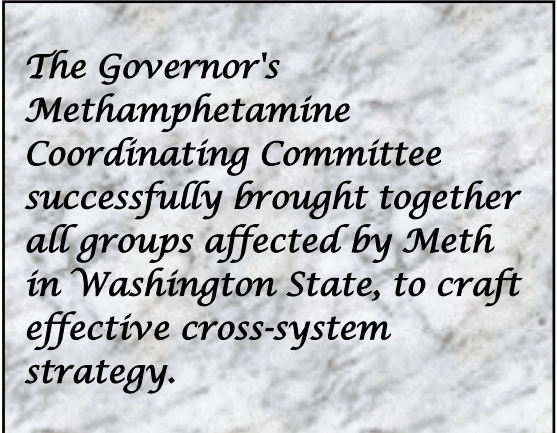
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## I. RECOMMENDATIONS FOR DEVELOPMENT OF CROSS-SYSTEM COLLABORATION

There have been many successes for cross-system collaboration during the two years since the Council released its 2001-03 policy recommendations. Two primary examples are Methamphetamine Abuse and Prevention System Reform.

### Combating Methamphetamine Impacts

In early 2000, the Council released the report Methamphetamine Abuse in Washington State. That report covered prevention, treatment, and law and justice impacts, as well as environment and public health concerns, and strategies for working with drug-affected children and families. Until 2002, Washington State continued to rank second only to the much more populous state of California in the number of illegal Meth labs and other Meth-related impacts. The report recommended collaborative, cross-system planning and cooperation as the process that was needed to control the Methamphetamine epidemic. (Governor's Council on Substance Abuse, 2000.)



*The Governor's  
Methamphetamine  
Coordinating Committee  
successfully brought together  
all groups affected by Meth  
in Washington State, to craft  
effective cross-system  
strategy.*

Following the release of the Council's report, the Governor appointed an interagency taskforce to develop cross-system implementation recommendations. This group was successful in developing a package of cross-system recommendations that were adopted by the Governor in his 2001 budget proposal.

The Governor has since appointed a more long-term, interagency group to coordinate Meth reduction efforts. The Governor's Methamphetamine Coordinating Committee has been successful in bringing together all the affected groups in Washington State to craft an effective, cross-system strategy. This effort has also been successful in obtaining federal financial assistance to help Washington State deal with the Meth problem.

A major 2003-05 recommendation of the Governor's Council is that this coordinated strategy to deal with the Methamphetamine impacts be continued. (See pg. 36.)

### Prevention System Reform

A soon to be released State Substance Abuse Prevention Plan for the State of Washington is the result of a cross-system planning effort over the last three years. Through a State Incentive Grant (SIG) from the Center for Substance Abuse Prevention, the Division of Alcohol and Substance Abuse facilitated a plan development process that involved 10 state agencies and offices, along with broad representation from community stakeholder groups. A SIG advisory group reflecting this representation was co-chaired by the Governor's Council on Substance

Abuse and the Division of Alcohol and Substance Abuse's Citizen Advisory Council. The result of this three-year planning process is six objectives for development of our state's prevention system agreed on by all the participants in this planning process. (Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.)

### **Program Areas Recommended for Cross-System Improvement**

During the development of their 2003-05 Policy Recommendations to Reduce Substance Abuse in Washington State, the Governor's Council on Substance Abuse identified several areas where cross-system collaboration needs to be improved. These are presented here as recommended policy directives for implementation by state and local agencies to provide a more collaborative and effective process for reducing substance abuse and its impacts.

The Council's 2003-05 recommendations include cross-systems coordination, data sharing, working from research validated models, and cross-training for the professionals and agencies that work with people whose lives are impacted by substance abuse.

*The President's 2002  
National Drug Control  
Strategy calls for "an honest  
effort to integrate"  
prevention, treatment, and  
law enforcement strategies  
against substance abuse and  
addiction.*

*Office of National Drug Control  
Policy, 2002*

### **Continue to Develop Cross-System Collaboration for Chemical Dependency Treatment**

This is an issue that crosses Treatment, Law & Justice, and Prevention.

The Governor's Council on Substance Abuse continues to support enhancing outpatient and inpatient treatment that emphasize access to treatment for youth, pregnant women, and parents with children.

Recent developments with drug sentencing reform have brought many stakeholders together to develop a system to support chemical dependency treatment alternatives for nonviolent drug offenders. Research has shown that criminal recidivism is lower for prisoners who have participated in the drug treatment program. (Taylor, 2000.) Treatment alternatives include adult and juvenile drug courts and treatment programs provided during incarceration.

Treatment is also a prevention issue since research has documented that family history of abuse is a primary risk factor that increases the likelihood that youth will develop substance abuse problems. (Hawkins and Catalano, 1996.) Treating the parents' substance abuse reduces the likelihood that children of these parents will develop substance abuse problems.

## **Increase the Use of Research-Based Models**

There is now a considerable body of research that demonstrates which program models are most effective models for preventing substance abuse and treating chemical dependency. The Governor's Council recommends that all substance abuse prevention, treatment, and law and justice agencies stay current with substance abuse and chemical dependency research. There is also a growing body of research to document the law and justice based models that are most effective in reducing substance abuse. (Taylor, 2000.)

The Council recommends that the program models proven effective through documented research studies form the foundation for programs targeting substance abuse and chemical dependency for specific problems and populations.

## **Chemical Dependency Cross-Training and Education for all Professionals Who Work with Drug-Affected Clients**

The Governor's Council recommends chemical dependency cross-training for professionals working in corrections, children's services, public health, mental health, programs for persons with physical and mental disabilities, medical programs, insurance companies, and law and justice programs. The Council recommends this as a strategy for improving the quality, consistency, and cost-effectiveness of treatment and recovery services for drug-affected clients.

There are already many good examples of cross-training models. One such model was developed by The Washington Institute for Mental Illness Research and Training. Since 1995 more than 1500 case managers, counselors, administrators, and others working with clients with chemical dependency and mental illness as co-occurring disorders have attended week-long case management academics through The Washington Institute. (Washington Institute for Mental Illness Research and Training, 2002.)

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## II. CHEMICAL DEPENDENCY TREATMENT

### Priority Statement

**Expand Treatment Capacity.** Reliable studies indicate that as many as one in ten adults in the United States is drug or alcohol dependent. In Washington State, the Division of Alcohol and Substance Abuse (DASA) oversees a system for accreditation of both public and private drug and alcohol treatment programs, and the financing of treatment for severely addicted, low-income people. Currently 575 organizations are certified by the state as treatment providers. Thirty-five to 40 percent of these providers receive public funding for the services their clients receive. The rest serve only private pay clients. The publicly funded providers are able to serve only 1 out of 5 individuals who are eligible for their services. Expanding treatment capacity to 40% of the low-income populations in need, with special emphasis on criminal justice populations, youth in crisis, pregnant women, and parents with children, is a key issue for policy makers and legislators in Washington State.

### Key Policy Questions

- What is the level of alcohol/drug abuse and need for treatment among various populations in the State of Washington?
- To what extent does untreated chemical dependency impact others systems and budgets?
- To what extent does alcohol/drug treatment work? Does treatment reduce the need for, and costs of, other services?
- What is the current status of access to services for people in need?
- What is the impact of budget cuts to publicly funded treatment services?

### Key Issues

**Question 1.** *What is the level of alcohol/drug abuse and need for treatment among various populations in Washington State?*

Based on a 1999 study conducted by the Department of Social and Health Services, Research and Data Analysis, 407,000 adults living in households in Washington State were estimated to be in need of substance abuse treatment. (TARGET: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1997.)

This represented 10 percent of the total adult population. The estimated need for treatment, for adults living in households with incomes above

*An estimated 437,842 adults living in Washington State in 1998 needed treatment for substance use or abuse.*

*Department of Social and Health Services,  
Division of Alcohol and Substance Abuse, Research and Data Analysis, 1999*

200 percent of the Federal Poverty Level (FPL), was 9.7%. The same 1999 study by DSHS estimated that 11.2 percent of adults living in households at or below 200 percent of the FPL were in need of substance abuse treatment. By current calculations, 18,350 adolescents (12 to 17 years of age), and 90,642 adults are in need of publicly funded treatment.

Estimates of treatment need vary by race and ethnicity. The following are estimates of the number and percentage of adults living at or below 200 percent of the FPL in need of treatment by race/ethnicity:

- 4,770 or 18.2% of Native Americans
- 93,416 or 12.4% of Caucasians
- 3,422 or 8.2% of African Americans
- 7,769 or 7.3% of Hispanic
- 1,627 or 2.3% of Asian/Pacific Islanders

***Question 2. To what extent does untreated chemical dependency impact other systems and budgets?***

A community's failure to treat the problem of alcoholism and drug addiction is enormously expensive. Research from the University of Washington indicates that in 1996 alone, substance abuse cost the citizens of Washington over \$2.5 billion, including health care costs, social welfare programs, lost productivity, crime, and extra law enforcement costs. (T.M. Wickizer, K. Campbell, A. Krupski, & K. Stark, 1999.)

*Washington State's \$2.5 billion price tag during 1996 included health care costs, social welfare programs, lost productivity, crime, and extra law enforcement costs.*

Drug and alcohol addiction is a major contributor to poverty, crime, family disintegration, and to government spending at the local, state and federal levels. Individuals with addictions, who do not receive treatment, commit more crimes, suffer more health problems, work less and utilize more public assistance resources. They also have higher rates of child neglect and abuse, unplanned pregnancies, homelessness, and psychiatric hospitalizations. Youth with substance abuse problems have higher truancy and school dropout rates, as well as poor school achievement.

***Question 3. To what extent does alcohol/drug treatment work? Does treatment reduce the need for and costs of other services?***

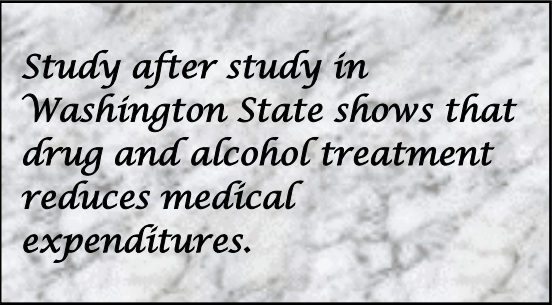
It has been repeatedly demonstrated by research that substance abuse treatment saves money. For every public dollar invested in alcohol/drug treatment in Washington State, \$3.71 is saved in medical care and criminal justice costs over the following four years. (Office of Research and Data Analysis, Washington State Department of Social and Health Services, 1997.)

## Substance Abuse Treatment Impacts

Providing substance abuse treatment has been shown to have the following impacts:

### Health Care

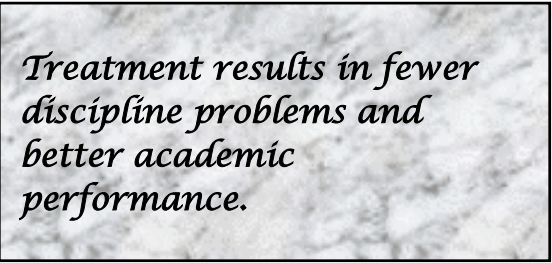
- **Reduces inpatient psychiatric hospitalization**—Compared to the year before treatment, use of inpatient psychiatric services by clients with co-occurring disorders that received residential substance abuse treatment, declined by 68 percent in the year after discharge. Likewise, use of inpatient psychiatric services by clients receiving involuntary treatment services declined by 56 percent in the year after discharge. (C. Maynard, and G. Cox, 1999.)
- **Decreases use of crisis mental health services**—Compared to the year before treatment, use of crisis mental health services by clients with co-occurring disorders that received residential substance abuse treatment, declined by 64 percent in the year after discharge. Likewise, use of crisis mental health services by clients receiving involuntary treatment services declined by 67 percent in the year after discharge. (C. Maynard, and G. Cox, 1999.)
- **Lowers use of major medical services**—The average medical costs for ADATSA patients who received chemical dependency treatment were \$4,500 lower than untreated patients over a five-year follow-up period. For ADATSA patients with Medicaid medical expenses prior to admission, chemical dependency treatment was associated with \$7,900 in overall savings in medical expenses over a five-year follow-up period. (TARGET: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1997.) Substance abusing women who received chemical dependency treatment prenatally were less likely to have a low birth weight baby. (L. Cawthon, 1993.) The average medical costs for children during the first two years of life were lower for women receiving treatment prenatally. The fetal death rate was one-third that of untreated substance abusing pregnant women. (L. Cawthon, and L. Schragar, 1995.)
- **Lowers Medicaid costs for Supplemental Security Income (SSI) eligible clients**—The average monthly medical costs, including estimated chemical dependency treatment expenses, were \$540 lower per person among SSI recipients who received chemical dependency treatment than medical costs alone for those who needed chemical dependency treatment but did not get it. Over a 12-month period, this results in savings of \$6,480 per person. (S. Estee, and D. Nordlund, 2001.)



*Study after study in Washington State shows that drug and alcohol treatment reduces medical expenditures.*

### Education System

- **Reduces the incidence of discipline problems in school**—following substance abuse treatment, the number of adolescents reporting any school discipline problems dropped by 50 percent. (New Standard, Inc., 1997.) School



*Treatment results in fewer discipline problems and better academic performance.*

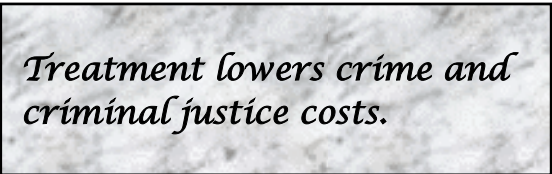
expulsions for Becca\* youth declined from 31 percent before treatment to 7 percent after treatment. (R. Brandon, 1999.)

- **Results in improved school performance and academic achievement**—following inpatient treatment, the number of adolescents receiving A's increased from 13 percent to 34 percent, and the number receiving F's decreased from 36 percent to 17 percent. Trends for adolescents receiving outpatient treatment were very similar. (New Standards, Inc., 1997.)
- **Results in better attendance**—School enrollment for Becca youth who received intensive inpatient treatment increased from 52 percent to 69 percent. (R. Brandon, 1999.)

### **Criminal Justice/Drug Court System**

- **Lowers crime and criminal justice costs for both youth and adults**—a significantly lower percentage of adolescent patients were under legal supervision 18 months after treatment. (New Standards, Inc., 1997.) A study of over 450 chemically dependent youth in Washington State showed that felony arrests decreased 56 percent between the year before and the year after treatment for inpatient clients and 54 percent for outpatient clients. Misdemeanor arrests decreased by 46 percent for inpatient clients and by 40 percent for outpatients. (New Standards, Inc., 1997.)

Depending on the type of crime reported (violent crimes, property crimes, domestic violence, public order offenses, drug offenses, and drunken driving), criminal arrests decreased between 5 percent and 29 percent among adults receiving chemical dependency treatment. (B.L. Baxter, and J. Stevenson, 1998.)



*Treatment lowers crime and criminal justice costs.*

Self-reported illegal activity declined 85 percent among a sample of 570 adults discharged from publicly funded chemical dependency residential treatment (from an average of 4.1 days engaged in illegal activity in the 30 days prior to treatment admission to 0.6 days in such activities in the 30 days prior to the 6-month follow-up). The average 30-day earnings from illegal activity declined 93 percent from \$485 at admission to \$32 at follow-up. (M. Carney, and D. Donovan, 2000.)

A recently released study, linking DASA treatment records and arrest records from the Washington State Patrol, found that in the year after treatment there was a 33 percent decline in the number of arrests for felony offenses, and a 21 percent decline in total arrests (felony or gross misdemeanor). (B. Luchansky, L. He, and D. Longhi, 2002.) Regardless of whether clients had multiple arrests, one arrest, or no arrests prior to treatment, completing treatment and staying in treatment longer were associated with reduced risks for felony arrests. Completing treatment, compared with not completing treatment, was associated with a 21 percent reduction in the probability of a felony arrest in the 18 months following treatment

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\* The At-Risk/Runaway Youth Program was created by the "Becca" Bill legislation, formally known as the 1995 At-Risk/Runaway Youth Act, which provided funding to implement the "Becca" Bill. "Becca youth" are a small number of youth (about 200 per year), mostly age 14-16, 95% of whom meet national professional standards for intensive inpatient treatment.

discharge. Having a treatment episode lasting 90 days or longer was associated with a 32 percent reduction in the probability of felony arrest in the 18 months following treatment discharge.

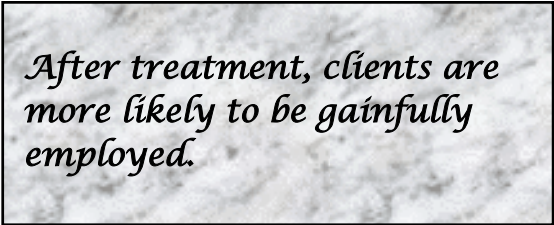
Drug Court participants who completed a full course of chemical dependency treatment were significantly less likely to be re-arrested in the 25 months following admission than individuals who failed, dropped out, opted out, or were ineligible for the Drug Court Program. (University of Washington, Alcohol and Drug Abuse Institute, 2000.) A study of drug courts conducted by the Washington State Institute for Public Policy estimates that drug courts can reduce the rate of subsequent criminal offending by 16 percent, which translates into an average savings of \$4,900 in criminal justice costs for each drug court participant. If drug courts cost an extra \$2,000 per participant, then taxpayers receive roughly \$2.45 in benefits for every dollar spent on the drug court. (Washington State Institute for Public Policy, 1999.)

### **Welfare System**

- **Reduces dependency on public assistance**—three out of five adult clients enrolled in Temporary Assistance for Needy Families (TANF), and completing publicly funded chemical dependency treatment became gainfully employed in the year following discharge, and earned an average of \$1,700 more during a two year period. (Office of Research and Data Analysis, Washington State Department of Social and Health Services, 2000.) (T.M. Wickizer, K. Campbell, A. Krupski, and K. Stark, 1999.)

### **Employment**

- **Results in increased employment**—approximately 60 percent of adult patients completing publicly funded chemical dependency treatment became gainfully employed in the year following discharge. AFDC (TANF) clients who are employed showed marked increases in earnings during the two years following chemical dependency treatment. (Office of Research and Data Analysis, Washington State Department of Social and Health Services 2000.)
- **Results in higher wages from employment**—completing a full continuum of treatment was associated with higher post-treatment wages. ADATSA clients who completed treatment earned \$403/month as compared to \$310/month for those who completed part of treatment and \$265/month for those who received no treatment. (T.M. Wickizer, J. Joesch, D. Longhi, A. Krupski, and K Stark, 1997.)



*After treatment, clients are more likely to be gainfully employed.*

### **Children's Services**

- **Reduces Child Protective Services referrals and child welfare system costs**—DSHS' Office of Children's Administration Research found that substance abuse was involved in 49 percent of reported child abuse incidents in Washington. Evidence from national studies suggests that between 40 percent and 80 percent of all child abuse and neglect cases involve

parental substance abuse. Children whose parents abuse alcohol and drugs are almost three times more likely to be abused and more than four times more likely to be neglected than children of parents who do not abuse alcohol and drugs. Children whose families do not get appropriate substance abuse treatment are more likely to remain in foster care longer, and to re-enter foster care after they are returned home.

Adolescents in foster care were found to be more likely than those living in their parents home to have a current substance abuse disorder (10 percent as opposed to 6 percent) or a current need for treatment (12 percent as opposed to 8 percent). (E. Kohlenberg, D. Nordlund, A. Lowin, and B. Treichler, 1998-99.) Youth living in foster care first used drugs at an earlier age, and were almost twice as likely to have “ever used” marijuana than youth living with their parents. However, when use of substances during the year before the interview was examined, the two groups were almost identical, and use during the previous 30 days was significantly lower for youth in foster care.

The study suggests that foster care placement has a positive affect on adolescent drug use by providing protection, repairing damage, and buffering against risk factors. Adolescents in foster care are almost twice as likely as those living with their parents to report participating in self-help groups. Among adolescents in foster care, almost half (46 percent) of those needing treatment reported receiving either formal treatment or help from a doctor, teacher, counselor, or pastor. By comparison, only 32 percent of adolescents living with their parents and needing treatment received treatment.

Beyond the personal and social benefits of substance abuse treatment, DASA and the citizens of Washington have a vested interest in closing the existing treatment gap, and ensuring that more clients enter and successfully complete substance abuse treatment.

*Treatment helps ensure safer, healthier, more economically vibrant families and communities.*

#### **Question 4. What is the current status of access to services for people in need?**

##### **Treatment Need**

It is estimated that 9.7 percent of adults living above the FPL are in need of substance abuse treatment and 11.2 percent of adults living at or below 200 percent of the FPL are estimated to be in need of alcohol/drug treatment (108,992 persons). The highest need for treatment is among American Indians (18.2 percent) while the lowest need is among Asian/Pacific Islanders (2.3 percent). Caucasians, African Americans, and Hispanic populations have estimated treatment needs of 12.4 percent, 8.2 percent and 7.3 percent respectively. Estimates of treatment need are not available for youth ages 12 to 17.

##### **Level of Treatment Need Currently Met**

Information about treatment utilization and treatment gaps currently is not available for the population living in households above 200 percent of the FPL. DASA's **TARGET 2000**

management information system does not collect client information for this population. These individuals either pay directly for substance abuse treatment or health insurance programs through their employment cover the treatment, in part or completely. A significant percentage of individuals in this population do not have health insurance through their employment. For them, the cost of substance abuse treatment may be a barrier to participation in drug and alcohol abuse treatment.

Residents of Washington State, who have health insurance, benefit from the provisions of RCW 48.44.240. This RCW was implemented in January of 1988, and requires all group contracts for health care services to provide benefits for chemical dependency treatment. WAC 284-53-010 contains the standards for coverage of chemical dependency services. Currently, health insurance policies for groups must cover a minimum of \$10,680 of a subscriber's inpatient and/or outpatient substance abuse treatment costs in a 24-month period. The maximum co-pay is \$600 per year. There is not a lifetime maximum payout. Medically necessary detoxification is covered as an emergency medical condition, and may not be billed against the chemical dependency payments.

*Only one of every five adults estimated to need publicly funded treatment services in 2001 received it, creating a treatment-to-need gap of 80%.*

**Washington Basic Health (WBH)** is a state sponsored program that provides affordable health care coverage to low-income Washington residents through eight private health plans. Monthly premiums are based on family size, income, age and the health plan selected. Co-payments are required for most services. For those who qualify for WBH, state funds are used to help pay a portion of the monthly premium. WBH currently pays a minimum of \$5,000 of a subscriber's inpatient and/or outpatient substance abuse costs in a 24-month period. The subscriber pays a co-pay of \$10 per visit for outpatient treatment, and \$100 per admittance into inpatient treatment. There is a \$10,000 lifetime limit.

Legislation that was passed in 2002 limits the number of participants in WBH to approximately 123,600. As members leave the program, new members will be admitted from a waiting list. As of April 15, 2002, there are 20,836 individuals on the waiting list. An average of three to four thousand individuals move off the waiting list and onto medical plans each month. Sixty-three percent have been on the waiting list for over sixty days. Limitations on program participation and waiting lists create barriers to treatment for individuals waiting for medical coverage through WBH. Both the legislature and concerned stakeholders have expressed interest in making WBH chemical dependency treatment benefits consistent with the chemical dependency treatment benefits in other health plans in the state.

In Washington State there is a broad continuum of publicly funded substance abuse services for individuals living in households with incomes at or below 200 percent of the FPL. The services include diagnostic evaluation, alcohol/drug detoxification, outpatient treatment, methadone treatment for opiate addicts, intensive inpatient treatment, recovery house services, long-term residential care, youth residential, and outpatient treatment and residential treatment for pregnant and parenting women (with child care), and treatment for co-occurring disorders. Specialized

support services for eligible individuals include childcare, translation services, transportation assistance, youth outreach and case management, and cooperative housing support. Twenty-one thousand five hundred seventy-four adults, representing 19.4 percent of the adults estimated to need publicly funded treatment services, were admitted to substance abuse treatment in SFY 2001. Only one out of every five adults estimated to need treatment received it, creating a treatment gap of approximately 80 percent.

Treatment utilization varies by population group. In SFY 2001, 57.5 percent of African Americans estimated to need treatment, were admitted to chemical dependency treatment. Likewise, 50 percent of American Indians in need of treatment received it, 21 percent of Asian/Pacific Islanders, 17 percent of Hispanics, and 16.5 percent of Caucasians. The treatment utilization rate for youth was estimated to be 22.9 percent.

***Question 5. What is the impact of budget cuts to publicly funded treatment services?***

- Reduction of the Treatment Accountability for Safe Communities programs effective July 2002 (\$1.036 million GFS).
- Funds to expand treatment capacity for the gravely disabled is reduced to \$1.0 million in FY 2003 (\$1.8 million GFS).
- Delay in the opening of a new CD Involuntary Treatment Facility in Eastern Washington (\$800,000 GFS).
- A vendor rate increase for FY 2002 is reduced from 2.3 percent to 1.5 percent (\$835,000 GFS).
- There are cuts of \$571,000 to the Violence Reduction and Drug Education (VRDE) funds.
- A \$275,000 cut to the Public Safety Education Account (PSEA).

In addition, budget reductions for the Work First Budget also affect DASA clients, including:

- \$4 million for drug and alcohol services designed to help TANF parents enter the job market or keep their job was eliminated. This included \$2.5 million for inpatient and outpatient treatment services and \$1.5 million to fund the placement of chemical dependency professionals in local welfare offices around the state. The \$2.5 million in treatment funding generated about \$1.5 million in Medicaid match, which means the total loss is approximately \$5.5 million for SFY 2003.
- The Safe Babies Safe Moms Project, which provides intensive case management, non-medical CD treatment, and other services to low income parents of drug-affected babies, was slated to receive \$878,000 in federal TANF funding to allow the project to continue for SFY 2003. The Governor vetoed the proviso, but provided \$878,000 of State General Funds. The State General Funds can be matched by federal dollars providing a total of \$1,756,000 to allow the evaluation of these projects to be completed. This is a net reduction of \$944,000 over the current funding level.

*Budget cuts will significantly affect the availability of public treatment services to those most in need of them during 2003 and beyond.*

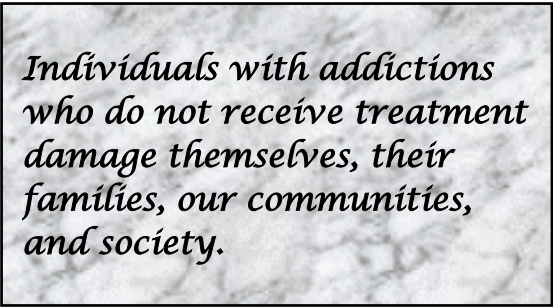
Through intra-agency collaboration, the Economic Services Administration (ESA) has committed \$3.0 million of their state funds to replace the lost TANF treatment funding. \$878,000 goes to Safe Babies Safe Moms and the remainder to drug and alcohol services. The state funds can be matched by federal Medicaid funds.

The following new funding is provided:

- **\$75,000** for the King County Juvenile Drug Court.
- **\$500,000** for treatment and training regarding pathological gambling.
- **HB2338 "The Drug Sentencing Reform Bill"** was passed into law by the 2002 Legislature. The bill reduces the seriousness level of certain drug offenses and creates a new drug offense-sentencing grid. Savings from reduced sentences will be used to fund drug treatment for offenders. Years one and two are planning years with no fiscal impact. Beginning year three, a projected 2,000 clients per year will receive services at a total cost of \$8.25 million per year.

### **Why it is Necessary to Fund Alcohol and Drug Treatment Programs**

History and research have repeatedly demonstrated the high cost of a community's failure to treat the problem of alcoholism and drug addiction. Individuals with addictions who do not receive treatment commit more crimes, suffer more health problems, work less, and utilize more public assistance resources. They also have higher rates of child neglect and abuse, unplanned pregnancies, homelessness, and psychiatric hospitalizations. Youth with substance abuse problems have higher truancy and school dropout rates, as well as poor school achievement.



*Individuals with addictions who do not receive treatment damage themselves, their families, our communities, and society.*

Research shows that publicly funded alcohol/drug treatment:

- Reduces inpatient psychiatric hospitalization
- Decreases the use of emergency rooms
- Lowers the use of major medical services
- Lowers crime and criminal justice costs
- Reduces the incidence of discipline problems in school
- Results in improved school performance and academic achievement
- Results in better attendance
- Reduces dependency on public assistance
- Results in increased employment and higher wages

- Reduces Child Protective Services referrals and child welfare costs
- Helps ensure safer, healthier, more economically vibrant families and communities

The cost of funding alcohol/drug treatment is more than offset by savings in other public supported systems. For every public dollar invested in alcohol/drug treatment in Washington State, \$3.71 is saved in medical care and criminal justice costs over the following four years. The citizens of Washington have a vested interest in closing the existing treatment gap, and ensuring that more clients enter and successfully complete substance abuse treatment.

## **Emerging needs and challenges**

- **Closing the treatment gap**—as indicated, the biggest challenge facing DASA is increasing the number of people under 200 percent of the federal poverty level being served through the DASA funded treatment system. At current level funding, DASA can serve 24,664 clients per year—representing a statewide penetration rate of 22.6 percent, or a treatment gap of 77.4 percent.
- **Expanding treatment for adolescents and troubled youth**—the need for community-based treatment services for troubled youth who are drug dependent is particularly great, and there is a shortage of treatment for those involved in the state’s juvenile justice system. Most alcohol and drug treatment programs designed for adults are not equipped to adequately and appropriately serve adolescents in need. Currently, there are over 200 youth on a waiting list for adolescent residential treatment.
- **Providing services for pregnant and parenting women**—10 percent to 12 percent of the approximately 80,000 births per year in Washington are to women who used alcohol or drugs during their pregnancy. (L. Cawthon, 1997.) There is a critical need for gender-appropriate treatment and prevention/early intervention services for substance abusing pregnant women who create health risks to themselves and the unborn children.
- **Providing services for individuals involved in the criminal justice system**—21 percent of inmates in Department of Corrections custody were convicted of nonviolent drug offenses. Between 60 and 80 percent of inmates are estimated to be in need of chemical dependency treatment. With the passage of the 2002 Drug Sentencing Reform legislation it will be possible to divert a significant portion of offenders from prisons and jails to supervised community-based treatment. Research indicates that chemical dependency treatment can result in reduced criminal recidivism, providing further savings as offenders are diverted. Inpatient treatment also needs to be expanded. Providing effective treatment in prison makes it more likely that offenders will make a safe transition into the community, where they will also need to be able to access community based treatment.

## **RECOMMENDATIONS**

1. **Close the treatment gap by increasing the number of low-income adults and youth who receive chemical dependency treatment services from 22.6 percent to 40 percent of the estimated need. Cost is \$35.1 million.**

## Fiscal Impacts

An analysis prepared by DASA in April of 2000, estimated that a total of 108,922 low-income adults and youth in Washington were in need of publicly funded substance abuse treatment. At the current level of funding, DASA can provide services for 24,664 of these individuals, achieving a penetration rate of 22.6 percent of those in need. It was estimated that it would cost an additional \$35.1 million dollars to increase the penetration rate to 40 percent of those in need. This was based on a per-person average treatment cost of \$1,853. The following table provides summary information for three major sub-groupings:

POPULATION SUB-GROUP	NUMBER IN NEED W/O HEALTH CARE COVERAGE	CURRENT SERVICE LEVEL	CURRENT PENETRATION RATE	COST TO ACHIEVE 40% PENETRATION RATE
Adolescents (ages 12 to 17)	18,350	4,213	22.9%	\$5.8 million
Adults w/ children under 18	42,717	12,432	29.1%	\$8.6 million
Adults w/o children	47,925	8,019	16.7%	\$20.7 million
TOTAL	108,992	24,664	22.6 %	\$ 35.1 million

## **2. Revise the chemical dependency treatment benefit in the Washington Basic Health Plan to be consistent with the chemical dependency treatment benefits in other group health benefit plans.**

By state law, health insurance policies for groups must cover a minimum of \$10,680 of a subscriber's inpatient and/or outpatient substance abuse treatment costs in a 24-month period. The maximum co-pay is \$600 per year. There is not a lifetime maximum payout. The Washington Basic Health Plan covers \$5,000 of a subscriber's inpatient and/or outpatient substance abuse treatment costs in a 24-month period. The subscriber pays a co-pay of \$10 per visit for outpatient treatment, and \$100 per admittance into inpatient treatment. There is a \$10,000 lifetime limit.

## **Personal Stories**

*It seems like someone else's life when I think back to how insane my life was until I went to treatment. Come March I will have 12 years clean and sober...in a few months I will have my Master's degree, and last year I bought a house! A long way from when I first met you. Now that I have worked in the field for several years and have been very fortunate, I try to give back by coordinating the toy drive up here in the Oroville school district. There is a great deal of poverty and drug abuse here, so it keeps me forever grateful that my life has turned out as it has.*

*--Ramie and Family--*

*I got sober from a little nudge from the Judge. Fortunately, as a first time offender, I was offered treatment instead of jail time. I had a little girl and I was working, so going to jail would not have solved anything. I started going to an outpatient treatment program for moms funded by DASA. In addition to providing social support, treatment helped me to understand more about addiction. I found out that addiction is a disease, and learned about some of the biological*

*processes that occur. The people in my 12-step meeting introduced me to Oxford House, a transitional housing program supported by DASA. The Oxford House gave me 24-hour sober support, and my daughter was able to live there with me. I think the most important thing that I gained from living in an Oxford House was self-esteem...if it had not been for the support...I would have relapsed. While living there I started taking classes at the local community college. Today I have a Bachelor's degree in Psychology and a great job working with women who are pregnant and parenting and working on a life in sobriety. Today my 12-year-old daughter and I have security, reliable transportation, and a bright future.*

*--Deborah--*

*I am a recovering addict with 14 years of recovery from my addiction to alcohol and drugs. I struggled through 17 years of addiction that began at age 13, with alcohol, amphetamines and marijuana. I dropped out of (high) school in my freshman year. I had countless contacts with the juvenile justice system and school counselors, but at that time, so little was known about addiction, that no one asked me about my drug use. I reached adulthood with no education and no basic living skills. I held lots of minimum wage jobs, but none for more than six months. I became dependent on welfare to support my baby and myself. While my addiction progressed, my little girl survived a daily life of unpredictability and abandonment. I had contact with the legal system, child protection, and officials from my daughter's school. Finally, I was provided an opportunity for treatment for my addiction. Along with treatment I received temporary financial support to meet my basic living needs, help with housing, and training for employment and parenting skills. This was the boost that I needed to get my life back on track. I went back to school and this time I was able to keep a GPA of 3.9. I completed a bachelor's degree and I now work in the field of substance abuse. The most important part of my story is the effect of my recovery on my daughter. She returned to a stable home and a mother who could provide the parenting that she deserved. Today she is 25 years old, working full time, enrolled in college and working on a Ph.D. Recovery creates meaningful, productive lives.*

*--Cindy--*

*Our girls are getting out into the community. They have volunteered in various places and have experienced people appreciating them and thanking them. Whether it was for their volunteering at a nursing home, doing clean-up duty at a local church, helping at the humane society, or sharing their stories at schools...our girls are hearing things they have never heard before from a community they never knew could be so welcoming or affirming. This involvement leaves the girls with a lasting impression...whether from an 84 year old lady in a nursing home, or an 11 year old fifth grader, (the) words of praise and gratitude are not easily discarded in these hearts that have seldom heard..."thanks for sharing with us...or, Wow, you're pretty brave to get help."*

*--SeaMar Visions Recovery House--*

### III. SERVICES FOR DRUG-AFFECTED FAMILIES IN THE CHILD WELFARE SYSTEM

#### Priority Statement

The increased impact of substance abuse on children and families in the child welfare system requires increased emphasis on substance abuse intervention for affected families and enhanced substance abuse training and technical assistance for child welfare caseworkers.

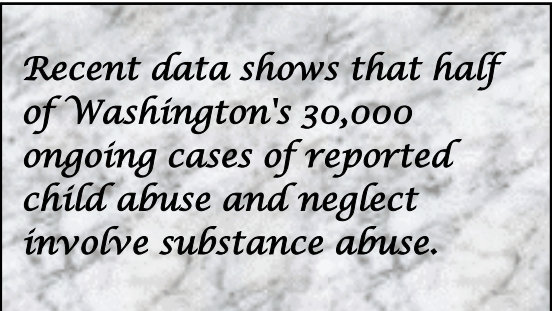
#### Key Policy Questions

- What are the impacts of substance abuse on the child welfare system and the children and families it serves?
- What protocols does the Department of Social and Health Services (DSHS) have in place for dealing with drug affected families?
- What substance abuse training is available to child welfare workers, foster parents or caregivers that are working with children and families?
- Would the child welfare system and its clients benefit from having chemical dependency counselors as child welfare workers?
- What program elements and strategies lead to successful intervention and reunification of families impacted by substance abuse?
- The lack of a framework for cross-system collaboration between child welfare and chemical dependency professionals.
- What are the impacts on children in the foster care system who were raised in a household with substance abusing parents?

#### Impacts of Substance Abuse

Numerous studies have reported that somewhere between one-third and two-thirds of substantiated child abuse and neglect cases involve substance abuse. (Report to Congress, 1999.) Some studies have reported substance abuse as high as 80 percent among child welfare systems. (CASA, Columbia University, 1999.) Historical data in Washington State shows that 68 percent of parents or guardians of children placed out of home have a

substance abuse problem. (Department of Social and Health Services, Children's Administration 2000.) More recent data shows that half of the 30,000 ongoing cases of reported abuse and neglect involve substance abuse. (Department of Social and Health Services, Children's Administration, 2000.) Children brought up in these environments are more likely to be



*Recent data shows that half of Washington's 30,000 ongoing cases of reported child abuse and neglect involve substance abuse.*

removed from the home and are at higher risk of developing substance abuse problems of their own in the future.

## **Balancing Competing Timelines**

Child welfare mandates for decisions regarding permanent placements for children who are in foster care. Federal child welfare law requires that a permanency hearing to determine the long-term plan for a child be held within 12 months of a child's entry into foster care. The law also requires that a petition to terminate parental rights be filed after a child has resided in foster care for 15 of 22 months, unless there are compelling reasons not to do so, or other specific circumstances exist such as that the child is in the care of a relative or the family has not received planned services. (Report to Congress, 1999.)

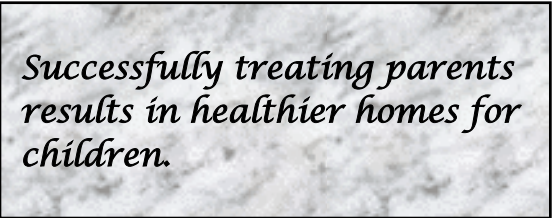
Often a parent's recovery timelines are in conflict with the federal child welfare laws. Recovery can take several years to achieve while a child's developmental timelines can't wait. Because of constraints imposed on social workers, it is important to maximize resources to the client to expedite their recovery process, thereby achieving a better chance at reunification with their children.

## **Department of Social and Health Services Protocols Currently in Place**

State law does require that substance abuse be included as a risk factor in the Risk Assessment Tool utilized by DSHS Children's Administration when investigating reported child abuse and neglect (RCW 26.44.030). Chapter 2000, Children's Administration Practices and Procedures Guide, states that the "perpetrator" should be referred for an alcohol/drug assessment if it is felt that alcohol/drugs was a contributing factor in the child abuse and neglect.

However, it appears that there is little direction as to how the Child Protective Services (CPS) worker is to determine if substance abuse is a contributing factor. This leaves the worker with little guidance and a wide range of subjective discretion for making this determination. The Practices and Procedures Guide further states that the worker does not have the authority to force the client to participate in a substance abuse evaluation without a court order. In another section the Guide states that the "perpetrator" can be referred for urinalysis testing "if available, within available funds." This may result in some clients not being monitored through urinalysis testing. Finally, the Practices and Procedures Guide does not appear to require workers to refer clients assessed as needing substance abuse treatment to such services except, in the case of prenatal / Newborn Drug / Alcohol exposure. In this instance, the worker is to "encourage" the mother to enter treatment.

If untreated the abuse of all drugs, including alcohol, place the parent at higher risk to abuse or neglect their children. (L. Cawthon, & L. Schrager, 1995.) Successful treatment of parental substance abuse means that parents are able to provide a more stable, safer, and healthier home environment for their children (T.M. Wickizer, K. Campbell, A.



*Successfully treating parents  
results in healthier homes for  
children.*

Krupski, & K. Stark, 2000.) (T.M. Wickizer, & D. Longhi, 1997.) It also increases the likelihood that parents will be able to train for and retain employment that will allow them to provide for their children. (T.M. Wickizer, J. Joesch, D. Longhi, A. Krupski, K. Stark, 1997.) (T.M. Wickizer, 2001.) (B. Luchansky, M. Brown, D. Longhi, K. Stark, A. Krupski, 2000.) To accomplish these outcomes, the DCFS protocols for working with substance abuse-affected families need to be strengthened.

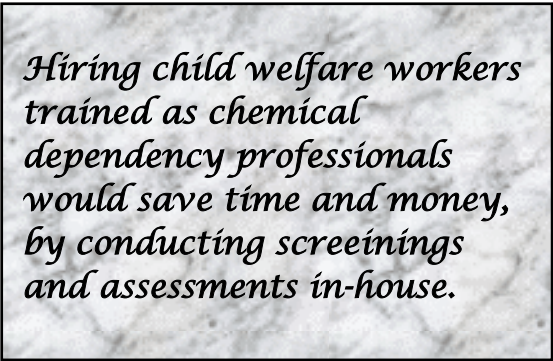
A prime example of the impact of substance abuse on drug-affected families can be seen in the increase in Methamphetamine-addicted parents involved with the child welfare system. Of particular concern is the increase in the number of children found at illegal methamphetamine labs. The majority of these children are the victims of child abuse or neglect and will need the protection of the child welfare system. Most of these children end up in foster care. For the protection of these drug-endangered children the DSHS Children's Administration should work with law enforcement to establish statewide standards for lab response protocols.

### **Training for Child Welfare Workers**

DSHS, in the Guide 3221 Drug and Alcohol Assessment, states that "the department shall provide appropriate training for persons who conduct the investigations. The training shall include methods of identifying indicators of abuse of alcohol or controlled substances." The Guide does not address how much training nor does it reference referral protocols or understanding the treatment system or drug testing protocols. Workers should receive training on alcohol/drug screening, basic addictions overview, drug testing, understanding the treatment system, and referral/reporting/monitoring protocols.

### **Hiring Chemical Dependency Counselors in Child Welfare System**

Hiring child welfare workers who are also chemical dependency professionals could significantly improve the effectiveness and efficiency of these workers when handling substance abuse cases. These workers would be able to conduct in-house screenings and assessments thus reducing the time and cost involved with referring cases to outside vendors. These workers could also help consult with and train other workers in the management of substance abuse cases. DSHS, Children's Administration currently has no policy for recruitment of workers with such skills.



*Hiring child welfare workers trained as chemical dependency professionals would save time and money, by conducting screenings and assessments in-house.*

## **RECOMMENDATIONS**

- 1. DSHS Children's Administration should conduct an analysis of the prevalence and impact of substance abuse in the child welfare system, how many clients are identified in need of substance abuse treatment, how many receive treatment of those in need, and the family outcomes for those receiving treatment.**
- 2. DSHS Children's Administration should identify and implement program strategies that lead to successful intervention and reunification for families with children in foster care.**
- 3. DSHS Children's Administration and the Division of Alcohol and Substance Abuse should work to develop a framework for cross-system collaboration to enhance services to children and families.**
- 4. DSHS Children's Administration should review and strengthen its policies and protocols to require workers to:**
  - a. Refer all clients for a chemical dependency assessment when there are possibilities of alcohol or substance abuse problems.
  - b. Refer all clients to substance abuse treatment where the assessment demonstrates such need.
  - c. Follow procedures (to be developed by department) in cases where the client has been referred to treatment but refuses to participate or drops out prematurely.
  - d. DSHS Children's Administration should work with law enforcement to establish protocols on how to respond to, and intervene on behalf of, drug-endangered children found at drug lab sites.
- 5. DSHS Children's Administration should review its current training practices related to alcohol and substance abuse to determine if they are adequate for dealing with the increase in drug related child welfare cases.**
- 6. DSHS Children's Administration should recruit child welfare workers who are also chemical dependency professionals so there is at least one such worker in each office. This could be accomplished as vacancies occur.**

## **IV. COORDINATED STRATEGY FOR DEALING WITH METHAMPHETAMINE IMPACTS IN WASHINGTON STATE**

### **Priority Statement**

The Governor's Council on Substance Abuse recommends that the coordinated, cross-system strategy in place in Washington State be continued to provide an effective effort to control and reduce the impacts of Methamphetamine abuse in Washington State.

### **Key Policy Questions**

- How effective are the outcomes of current cross-system efforts?
- What level and type of cross-system efforts will be necessary to bring this problem under control in Washington State?
- What are the specific policy actions that should be taken during the 2003-05 Biennium?

### **Development of Methamphetamine Abuse Issues in Washington State**

Concerns about the impact of Methamphetamine (Meth) abuse in Washington State began in the early 1990s. Throughout the 1990s the rates for Meth-related crime, drug treatment admissions, and environmental contamination have continued to climb. According to researchers at the Northwest High Intensity Drug Trafficking Area (HIDTA) office, 36 of Washington's 39 counties reported at least one clandestine lab in 2001, and "nearly all cities and counties in Washington" say they now deal with Meth-related issues. (Northwest High Intensity Drug Trafficking Area, 2002.)

Amphetamines have been manufactured in the United States since 1887. Meth was first synthesized in 1919 and closely resembles amphetamines in chemical structure and pharmacological action. Early in the century, amphetamine was used in nasal decongestants, and for the treatment of narcolepsy and obesity. Amphetamines could be obtained without a prescription until 1951, and were originally promoted as safe, low-risk drugs. American, British, German, and Japanese troops relied on amphetamines as stimulants during World War II. During the 1950s-60s, physicians prescribed amphetamines, which were often advised for weight loss. During this same time period, amphetamines became widely available on the black market for use among athletes and long-haul truckers.

Meth gained popularity in the 1960s. During the 1960s "speed" (a.k.a. amphetamine) became popular in the Haight-Ashbury neighborhood in San Francisco, exceeding LSD and other hallucinogenic drugs in use. In the early 1960s intravenous administration of Meth, combined with development of tolerance for the drug, led to an escalation in the Bay area.

Nationwide, Meth use declined in the 1970s due to tight federal controls, aggressive law enforcement efforts, and a targeted public health campaign. In subsequent decades however, Meth regained popularity, and drug dealers began to operate illegal labs or rely on organized trafficking organizations to obtain their supplies. At present, Meth is manufactured illegally within the United States, or is imported in finished form from Mexico. Until recently the Meth epidemic was located primarily in the western part of the United States. Now however, Meth is appearing more and more frequently in the Midwestern and eastern portions of the country. (U.S. Department of Justice, 2001.)

As the Twentieth Century became the twenty-first, illegal Meth activity continued to multiply in Washington State. Mexican poly-drug trafficking organizations transport Meth and other illicit drugs here from Southern California and Mexican factories via land and water routes. The state's miles of accessible ocean beaches and rugged country along the border shared with Canada complicates interdiction efforts. In addition, the chemicals needed to manufacture Meth ("precursor" chemicals) are easily obtained in Washington State, in neighboring Canada, and even over the internet, even though new state and local laws regulate precursor purchase and possession. (Northwest High Intensity Drug Trafficking Area, 2002.)

Meth availability is abetted by a proliferation of illegal domestic labs. The *Draft NWHIDTA Threat Assessment for 2002* notes that local labs have become harder to identify. Reliance on the anhydrous ammonia production method, which requires less cook time and less physical space than other techniques, makes detection more difficult. This technique has become the prevailing Meth production process in the counties along the eastern edge of Puget Sound. (Northwest High Intensity Drug Trafficking Area, 2002).

*According to NWHIDTA, Meth labs have been found in motel rooms, apartments, garages, residences, and even in the trunks of stolen automobiles.*

*Northwest High Intensity Drug Trafficking Area, 2002*

## **Current Methamphetamine Impacts**

The first evidence of Meth's impact in Washington State was the rapid spread of illegal drug labs and associated increases in Meth trafficking. This tide quickly overwhelmed the resources of Washington's Department of Ecology, and of local public health and law enforcement agencies called upon to respond to lab sites and to investigate related crimes.

Since 1998, observers have noted a dramatic increase each year in the number of labs identified and investigated, leading some to designate Washington State as the site of a Meth "epidemic." The number of sites reported jumped

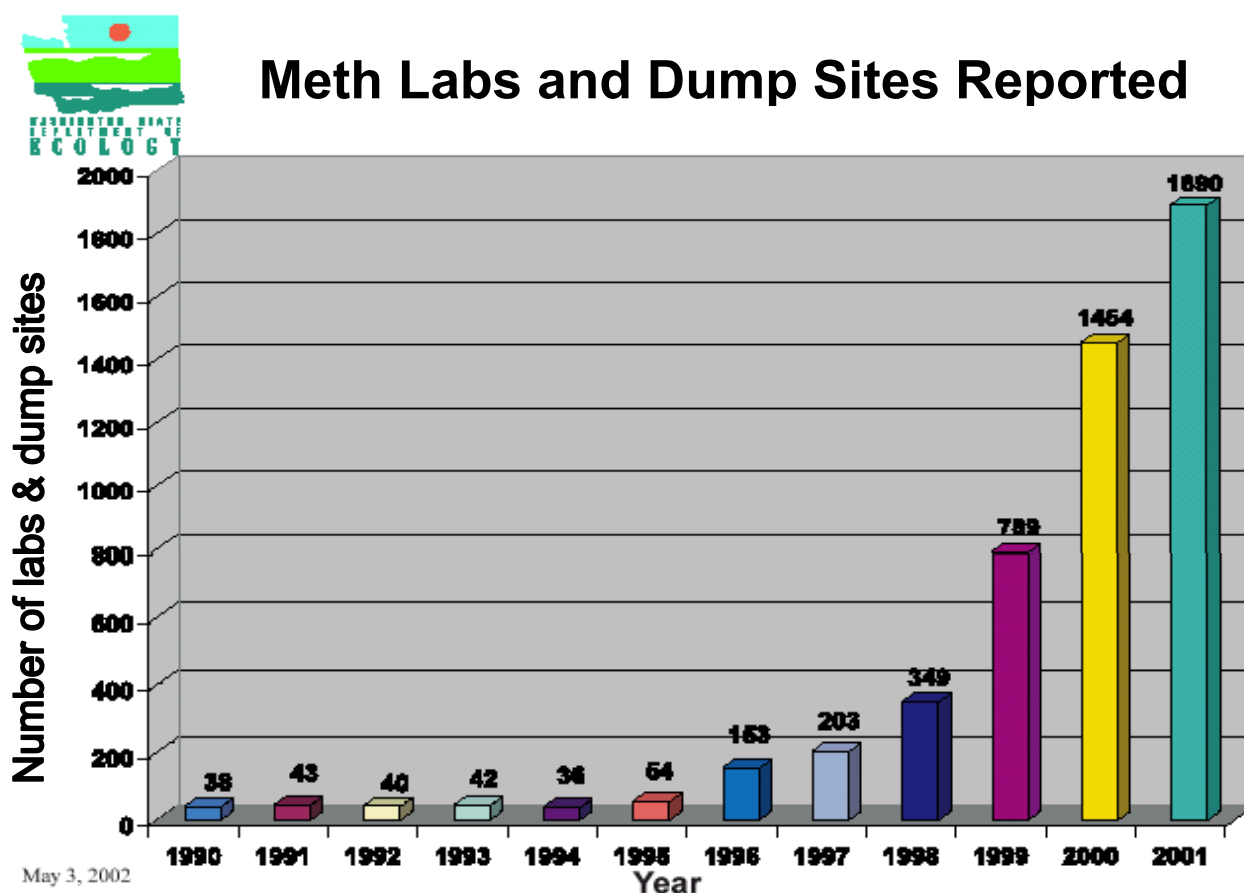
*The number of Meth labs and dumpsites reported annually statewide increased from 38 in 1990 to 1,890 in 2001.*

*Between January 1 and May 31, 2002, an additional 815 have been reported.*

*Washington State Department of Ecology, May 3 2002; June 2002*

from 349 in 1998 to 1,890 in 2001. Early data for 2002 show that lab numbers statewide continue to increase over last year, but the rate of increase is slowing. Moreover, Pierce County, which has historically accounted for around 40 percent of the state's total, is behind last year's pace. That alone, to this date, has kept the 2002 statewide total behind last year's trend. But at the same time, lab seizures are generally increasing in rural counties across the state, and stepped-up surveillance activities on Washington State's military installations since September 11<sup>th</sup> have turned up additional labs and dumpsites.

Analysts view this apparent move to more remote locations as a response in part to coordinated, cross-system surveillance and enforcement efforts in urban counties. (Northwest High Intensity Drug Trafficking Area, 2002.)



Organized drug traffickers and others continue to use Native American reservation lands as “stash locations and safe zones for operations” involving Meth and other illicit drugs, and as sites for all sizes of labs, including the superlabs which result in exceptionally large dumpsites. (Northwest High Intensity Drug Trafficking Area, 2002.) According to the Tribal Liaison for the Western District of the U.S. Attorney's Office, attacking the Meth problem on Tribal lands is particularly difficult. States (not Tribal law enforcement agencies) have jurisdiction over non-

Indians on tribal lands, most Tribal police forces are not equipped to handle dangerous chemicals, and currently federal law enforcement agencies are not routinely investigating relatively small drug cases on reservations. Similar jurisdiction problems affect assignment of responsibility for reservation lab and dumpsite clean up. (Roe , May 16, 2002.)

Production of one pound of Meth results in releases of poisonous gas and five to seven pounds of chemical waste which may be dumped into streams and rivers, flushed down toilets, or simply abandoned on private or public land. (U.S. Department of Justice, 2001.) Clandestine Meth lab sites themselves are contaminated by the highly toxic, corrosive, flammable, and explosive chemicals involved in manufacturing the drug. (U.S. Department of Justice, 1999.)

In Washington State, the Department of Ecology has accepted the responsibility of removing and disposing the gross contamination from Meth labs and dump sites; land owners must clean up the residual contamination. (Washington State Department of Ecology, May 29, 2002.) Local Health Officers oversee remediation of contaminated properties and determine whether or not a certified contractor or property owner will perform the clean up. Owners are responsible for the cost of clean up. Washington's Department of Health, which certifies drug lab cleanup workers, supervisors, and contractors, estimates contractors' cleanup costs for a 1,200 square foot home at \$6,000. This estimate does not include presampling expenses. (Washington State Department of Health, 2002.) After law enforcement has identified each lab, as many as five public agencies may be involved in its seizure: law enforcement; the local fire district; Child Protective Services; the Department of Ecology; and local health departments. Costs have not been tabulated across-systems and agencies.

While Washington State presently ranks third, behind only California and Missouri in numbers of clandestine Meth labs (El Paso Intelligence Center 2002), the impacts associated with illicit Meth production and abuse are broader than identification, seizure, and clean up of Meth sites alone.

The state's public agencies face issues related to: care of children caught in unhealthy conditions and disintegrating families; treatment of people abusing and addicted to Meth; issues related to

*"Jurisdictional issues play a tremendously important part in the increasing Meth problem on Tribal lands. The outside-of-the-reservation Meth problem and the inside-of-the-reservation problem are one and the same - they can't be separated. Tribal law enforcement needs to be cross-commissioned and recognized under the RCWs to arrest non-Indians on reservations."*

*Michael DeCapua  
Chief of Police  
Quinault Indian Nation*

*According to Washington State's Department of Ecology, 654 Meth-related incidents in 2001 were reported to that agency as "drug lab residential."*

*Washington State Department of Ecology, June 10, 2002*

injection drug users of Meth, whose sharing of infected needles can spread sexually transmitted and blood-borne infections (including syphilis, HIV and hepatitis C); regulation of the sale of Meth cooking equipment and precursor chemicals; and crimes related to Meth distribution and addiction.

## Children

Meth affects Washington State's children in a variety of ways. By 12<sup>th</sup> grade, 7.5 percent of public school students say they have tried Meth at least once, and 2.9 percent report using it during the past 30 days. (RMC Corporation, 2001.) Personal use of Meth is just one of many ways the drug shapes children's lives. Law enforcement agents seizing illicit Meth labs across Washington State during 2001 found a total of 175 children at these locations (out of 939 labs seized), with an average age of 7 ½ years. Three in five (111, or 63%) of these children were referred to Child Protective Services. At 80 sites, children evidenced chemical exposure. (Northwest High Intensity Drug Trafficking Area, May 24, 2002.) Data from the Department of Social and Health Services, Division of Child and Family Services (DCFS) describes the problem from another angle. As reported in a sample of intake narratives from 1996-1997, 38 percent of new referrals to DCFS alleged that the substance abuse was a primary problem for the primary caregiver, and 13 percent of those specifically mentioned Meth. (English, 2002.)

## Treatment

The rise in the numbers of amphetamine/Methamphetamine admissions to publicly funded chemical dependency treatment programs mirrors the bound in numbers of seized illegal labs. (At present, Washington State admission data for private treatment facilities is not reported or tracked). While public treatment admissions are still fewer in number than those for alcohol or marijuana abuse and addiction, the numbers show an 83.1 percent increase over the past five years from 3,206 in SFY 1996, to 5,869 in SFY 2000.

*"About 8 in 10 of children on my caseload are impacted by Meth. Their parents, often addicted to the drug, have left them in conditions of severe neglect. When taken into protective custody, these children are malnourished, exhibit severe developmental needs, and experience on-going medical and dental problems. They typically exhibit symptoms of Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactive Disorder (ADHD), recurrent severe depression, and other anxiety disorders."*

*Mariann Whalen  
Washington State Department of  
Social and Health Services*

*Numbers of injured and neglected children reported at Meth lab scenes increased 29 percent over the previous year, during 2001.*

*Northwest High Intensity Drug  
Trafficking Area, 2002*

The jump for treatment admissions of *injection* Meth users is also 83 percent over the same time period. (Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2001.) Research links illicit injection drug use, including that of Meth, when associated with sharing of needles and injection equipment, to transmission of sexually transmitted and blood-borne infections. (Washington State Governor's Council on HIV/AIDS and the Washington State Governor's Council on Substance Abuse Joint Workgroup, *Prevention of Blood-Borne Infections*, Olympia.)

Of 11,115 estimated drug-related emergency department episodes in Seattle during 2000, some 540 were related to Meth, 87 more than the previous year (Office of National Drug Control Policy, 2002). Seattle had the nation's fourth highest estimated rate of Meth-related emergency department visits (27 per 100,000 population) that year, among 21 large U.S. metropolitan areas studied (Substance Abuse and Mental Health Services Administration, 2002).

## Regulation

Legislators passed new laws relating to Meth during several recent sessions. This legislation includes controls on the sale and possession of precursors for Meth manufacturing, including pseudoephedrine, anhydrous ammonia, and lithium batteries. Offenders now receive longer sentences when convicted of manufacturing Meth where children are present.

*Seventeen Meth labs seized by Washington's law enforcement officials in 2001 were located near schools.*

*Northwest High Intensity Drug Trafficking Area May 24 2002*

## Crimes

According to the National Drug Intelligence Center, Meth-related crime is on the increase across the country. Law enforcement officials report child neglect, child and spousal abuse, sexual abuse, homicide, and property crime including mail and check fraud and identity theft, associated with Meth use. (2001.) In Washington State as well, Meth is linked to illegal activity. Fully a quarter (26.4 percent) of federal sentences handed down in Washington State between October 1, 1999 and September 30, 2000 were to drug offenders. Of those drug-related sentences, 23.8 percent involved Meth. (United States Sentencing Commission, 2000.) In 1999, the Arrestee Drug Abuse Monitoring Program found that in Spokane County, 20.1 percent of males and 26.6 percent of females arrested tested positive for Meth at the time of booking. Preliminary year 2000 figures for adult male arrestees echo the 20 percent statistic for Spokane; 10 percent of adult male arrestees in Seattle tested positive for Meth

*The rate of admission to publicly funded treatment programs for amphetamine / Methamphetamine use rose from 3,206 in SFY 1996, to 5,869 in SFY 2000 - an increase of more than 80 percent in just five years*

*Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2001*

between January and September of 2000. For comparison, 56 percent and 65 percent of 2000 male adult arrestees tested positive at booking for any drug, in Spokane and Seattle, respectively. (Taylor, 2001.)

## **Cross-System Methamphetamine Policy Action Strategies**

In early 2000, the Governor's Council on Substance Abuse released a report entitled Methamphetamine Abuse in Washington State. This report covered prevention, treatment, law and justice impacts, environmental and public health concerns, and strategies for working with drug-endangered children and families. Through Methamphetamine Abuse in Washington State, the Council recommended a collaborative planning process to deal effectively with Meth impacts through cross-system efforts. (Washington State Governor's Council on Substance Abuse, 2000.)

*One of every five arrestees in Spokane who agreed to testing came up positive for Meth at the time of booking into a correctional facility, during the first nine months of 2000.*

*National Institute of Justice  
Statistics; Taylor, 2001*

Following the release of the Council's report, Governor Gary Locke brought together an interagency taskforce to develop cross-system implementation recommendations. The taskforce's package of cross-system recommendations was subsequently adopted as part of the Governor's 2001 budget proposal. Governor Locke has since appointed a longer-term interagency group to coordinate Meth reduction efforts. The Governor's Methamphetamine Coordinating Committee brings groups affected by Meth in Washington State together to craft effective collaborative strategy. Members also worked to obtain federal financial assistance to help Washington State address the Meth problem, via a proposal asking Congress to supplement state and local funding for a comprehensive, community-based and statewide strategy to stop Methamphetamine abuse.

The resultant strategy, currently underway, consists of four coordinated elements. Responsibility for training and equipping additional personnel to expand regional response capabilities and perform proactive investigations statewide rests with law enforcement. The treatment community is focusing on expanding treatment admissions, especially among mothers with young children. Additional cleanup and mitigation staff respond to labs and dump sites, and reduce costs of cleanup by working to increase waste acceptance and disposal at county facilities. To enhance prevention, funding has been allocated to develop, train, and support Action Teams in all 39 counties.

In 2000, federal funding for this strategy began with the allocation of \$2 million to the Pierce County Alliance for implementation of their Washington State Meth Initiative. During the 2001 Initiative, the scope expanded to additional counties as funding increased to \$4 million. Sheriffs and other concerned professionals collaborated with members of Congress, the National Crime Prevention Council, and the Drug Enforcement Administration to convene the Washington State Meth Summit in August 2001.

Following the Summit, the Methamphetamine Coordinating Committee submitted a third proposal to Congress. This proposal was for \$15 million, to extend the strategy to all counties in the state.

## **RECOMMENDATIONS**

- 1. The Council recommends continuation of the Governor's Methamphetamine Coordinating Committee to develop, implement and sustain specific, cross-system strategies to reduce the impact of Meth abuse.**
- 2. The Council recommends an expansion of current efforts to provide training and technical assistance to develop local, community-based Meth action teams.**
- 3. The Council recommends that protocols for dealing with drug endangered children and families be implemented for Child Welfare agencies statewide. (See the Children's Services section of this report.)**
- 4. The Council recommends that the Council's 2000 Methamphetamine report be revised and updated during 2003. The intent would be to describe the efforts and outcomes of Meth strategies implemented since 2000, and to make recommendations for future action.**

## V. REDUCING UNDERAGE DRINKING IN WASHINGTON STATE

### Priority Statement

Underage alcohol use is an extremely serious problem that contributes to a wide range of problems from failing grades, truancy, and vandalism, to violence, unintended pregnancy, suicide, and death. Washington State can address this problem by adopting laws and support policies and strategies that have been shown to reduce underage drinking.

### Key Policy Questions Addressed

- Why should policy-makers care about underage drinking?
- What policy actions can state and local government take to reduce this problem?
- What policy and program actions have been shown to be effective in reducing underage drinking?

### Issue Summary

Underage use of alcohol can have immediate and potentially tragic consequences as well as long-range harmful consequences. Alcohol causes serious and potentially life-threatening problems for youth. Drinking is associated with risk-taking and sensation-seeking behavior among adolescents. The age at which a person first uses alcohol is a powerful predictor of lifetime alcohol abuse and dependence. More than 40 percent of individuals who begin drinking before age 13 will develop alcohol abuse or alcohol dependence at some time in their lives. (Grant & Dawson, 1997.)

*Fewer than half (43.6 percent) of the nation's high school seniors in 2001 said they thought people having five or more drinks once or twice each weekend were at great risk of harming themselves, physically or in other ways.*  
*University of Michigan*

Research has shown that there are a variety of policies and strategies aimed at the reduction of youth access to alcohol that can be effective. The following is a description of the types of policies that reduce the risk of underage drinking problems:

- Limiting access to alcohol by youth through increased enforcement and improvement of minimum purchase laws, reducing social availability, and controlling access in general. Research shows that people drink less and have fewer alcohol-related problems, when alcoholic beverage prices are increased or availability is restricted. (Cook & Moore, 2002.)

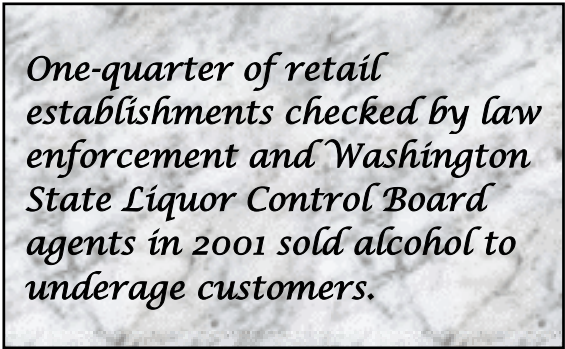
*Research points to policies effective in reducing youth alcohol access.*

This includes such activities as keg registration, the enforcement of laws against buying alcohol for minors, and teaching responsible beverage service techniques to reduce sales to minors.

- Strengthening and expressing community norms against underage drinking is a helpful strategy to reduce the activity. Some examples of these strategies are restrictions on use of alcohol in public places and at community events, advertising restrictions in public places, and restrictions on alcohol sponsorship at community events.
- Enhancing and enforcing school policies regarding alcohol use, teaching media literacy, and implementing research-based curricula have also proven to reduce and/or delay the use of alcohol and other drugs.
- Vigorously enforcing and publicizing the enforcement of zero tolerance laws and impaired driving laws in general help deter underage drinking. A specific example of one such deterrence is the administrative suspension of driving privileges. (Stewart 1998.)

In Washington State in 2001, there were 9,289 alcohol and drug arrests for an arrest rate of 13.4 per thousand youth aged 10-17. This is an 8 percent increase from 1990. (Governor's Juvenile Justice Advisory Committee, 2001.)

Also in 2001, the Washington State Liquor Control Board's (WSLCB) Enforcement and Education Division arrested 429 adults for the sale of liquor to minors. Its 67 enforcement agents handled 3,014 corrective actions involving sales to minors. Of the 1,716 liquor compliance checks conducted by law enforcement and the WSLCB in 2001, over 24 percent retail establishments sold to underage customers. (Washington State Liquor Control Board, 2001.)



*One-quarter of retail establishments checked by law enforcement and Washington State Liquor Control Board agents in 2001 sold alcohol to underage customers.*

The Washington State Traffic Safety Commission's Fatal Accident Report System indicates that from 1993 through 2000, there were 253 individuals ages 15-20 killed in alcohol-related crashes. This is 73 percent of all the fatalities from alcohol-related crashes. Of those 253 persons, 170 were driving.

According to the 2000 Washington State Survey of Adolescent Health Behaviors, alcohol remains the substance of choice for Washington's students in grades 6th through 12th. Additional survey findings indicate the following:

- The reported average age of first use of alcohol is 13.9 years old.
- An alarmingly high number of high school seniors (32 percent) reported binge drinking within the past two weeks.
- Most students in this survey also said that it would be "sort of easy" or "very easy" to obtain alcohol if they wanted it (84 percent of seniors, 71 percent of tenth graders, and 45 percent of eighth graders).

- Of students surveyed, 42 percent of sixth graders and 88 percent of seniors said they thought that kids would be unlikely to get caught by police if they drank alcohol in their neighborhood.
- Of students who said that they drink, most obtain it from friends, although 11 percent of seniors reported that they asked adults to purchase it for them or they buy it themselves.

The state of Washington has several efforts in place that address the issue of underage drinking and other substance abuse:

- County and tribal alcohol, tobacco, and other drug prevention programs and statewide prevention services such as mentoring, media, and a prevention clearinghouse are funded through the Department of Social and Health Services, Division of Alcohol and Substance Abuse (DASA).
- Community Mobilization Against Drugs and Violence funded through the Department of Community, Trade and Economic Development, Office of Community Development.
- DUI community task forces funded by the Washington Traffic Safety Commission.
- School-based prevention/early intervention program administered by the Office of the Superintendent of Public Instruction (OSPI) targeting students at-risk for developing alcohol, tobacco, and other drug related problems.
- Safe and Drug-Free Schools Programs funded through OSPI.
- Community Health and Safety Networks funded through the state Family Policy Council.
- The Reducing Underage Drinking Coalition (RUAD) oversees several Enforcing the Underage Drinking Laws grants from the federal Office of Juvenile Justice and Delinquency Prevention.
- DASA, the Liquor Control Board, and the Washington Traffic Safety Commission lead the coalition in collaboration with many other state and community organizations.

*In Washington State, schools, community groups, and state agencies are working together on the problem.*

Currently there are 11 community-based projects being funded and support for the College Coalition is in process.

## RECOMMENDATIONS

Washington State has enacted a number of laws, including keg registration and zero tolerance for youth under the legal age for alcohol use, which positively impact this issue. These laws have been shown by substance abuse research to be effective in reducing underage drinking. However, there is more that can be done.

The Governor's Council on Substance Abuse recommends:

- 1. A statewide program of alcohol outlet monitoring and enforcement of existing laws. To be successful, this policy could require an increase in the number of Liquor Control Agents, increased coordination between liquor enforcement and law enforcement agencies, and community-based “watchdog” groups.**
- 2. Provide and mandate training for retailers and retail employees (we already mandate training for servers) who sell alcoholic beverages about the zero tolerance law for selling or providing alcohol to minors. This training should emphasize training for non-English-speaking retailers and employees.**
- 3. Take policy action to restrict public alcohol advertising such as at sports and community events, outside convenience stores, and on billboards and buses.**
- 4. Consider an increase in the tax on alcoholic beverages. Prevention research documents that increases in price and reduction of access to alcoholic beverages reduce use. It also defines and reinforces the message that underage drinking is not an acceptable community norm for how to behave.**
- 5. Educate the public, especially parents, about the risks of underage drinking and their responsibilities to take action for the safety of underage youth and the community at large.**

## **VI. INCREASING KNOWLEDGE OF THE RISKS ASSOCIATED WITH THE USE OF MARIJUANA AND ENFORCEMENT OF MARIJUANA LAWS**

### **Priority Statement**

The Governor's Council on Substance Abuse recommends policy and program actions to:

- Increase knowledge of the risks associated with Marijuana use.
- Clarify enforcement standards for current laws related to Marijuana.

### **Key Policy Questions**

1. Knowledge of risks associated with marijuana use.
  - Current decreases in perception of harm from marijuana use are resulting in increases in use by youth. (University of Michigan, Monitoring the Future, 2001.)
  - The THC potency of marijuana has increased. (Drug Enforcement Administration, 2002.)
  - The current societal messages regarding harmful effects of Marijuana use are unclear and conflicting. (University of Michigan, 2001.)
2. Clarification of laws regulating access to and the use of marijuana.
  - Standards for implementation of RCW 69.51A (Medical Marijuana) have not been developed or implemented.
  - There is a lack of awareness and enforcement of RCW 69.50.102 pertaining to the sale of drug paraphernalia.

### **Issue Summaries**

#### **Increasing the Knowledge of Risks Associated with Marijuana Use**

For the last three years citizens throughout Washington have worked together on a coordinated plan for prevention services. Funded through a State Incentive Grant (SIG) from the Center for Substance Abuse Prevention, the process plan involved the collaborative work of many state and local agencies and community stakeholders. An advisory group for the SIG grant was co-chaired by the Governor's Council on Substance Abuse and the Division of Alcohol and Substance Abuse's Citizen Advisory Council. The goal of this plan is to coordinate all state and local prevention efforts to reduce the use of alcohol, tobacco and other drugs, including marijuana, that are illegal for use by youth.

Key to this effort will be improving education about the harmful effects of these drugs. Coordinated, local prevention plans will use research-based program models to target locally identified drug abuse impacts. One of eighteen objectives that will be used to measure

Washington State's substance abuse prevention efforts will be the reduction in the proportion of youth who report having used marijuana during the previous 30 days. (DASA, 2002.)

The following are examples of current substance abuse data that exemplify the impact that marijuana is having on Washington's youth.

- Results from the Monitoring the Future study show that between 1991 and 1997, 8<sup>th</sup> grade students' perception of harm from regular use of marijuana fell from 83.8 to 72.7 percent and 30-day daily use increased 500 percent from .2 percent to 1.1 percent. (University of Michigan, 2001.)
- Findings from the 2000 Washington State Survey of Adolescent Health Behaviors show that between 1990 and 1995, 8<sup>th</sup> grade students' perception of experiencing great harm from using marijuana fell from 47 percent to 29.4 percent and 30-day use increased more than 200 percent from 7.8 percent to 16.2 percent. Between 1995 and 2000, the perception of harm increased from 29.4 percent to 40.3 percent and 30-day use declined from 16.2 percent to 12 percent. (RMC Research Corporation, 2001.)

*Study findings in Washington State show that when students' perception of risk from using marijuana declines, use increases; when perception of risk rises, students' use drops.*
- Treatment data reported by the DSHS Division of Alcohol and Substance Abuse in their annual TRENDS report show that since 1994, marijuana became the most common drug of choice reported by adolescents entering chemical dependency treatment. Prior to 1994, the most common drug of choice among adolescents was alcohol. In 2000, nearly three times as many adolescents reported marijuana as their primary drug as those who reported that alcohol was their primary drug. (Department of Social and Health Services, Division of Alcohol and Substance Abuse, TRENDS, 2001.)
- WA State Prevention/Intervention Program Evaluation – For students referred to the school-based prevention/intervention program services in 2000-01, in the three months prior to referral, about three in ten had used tobacco (28 percent) or marijuana (32 percent). Sixty-one percent of students who completed the program evaluation survey when exiting the prevention/intervention program in 2000-01 reported understanding of moderate to great risk in occasional marijuana use.
- Increase in THC potency of marijuana – Overall, during the past two decades, the potency of some forms of marijuana has more than tripled. According to the University of Mississippi's 2000 Marijuana Potency Monitoring Project (MPMP), THC levels in marijuana rose from under 2 percent in the late 1970s and early 1980s to 6.07 percent in 2000. The MPMP reports that sinsemilla potency also increased, rising from 6 percent in the late 1970s and 1980s to 13.20 percent in 2000. (Drug Enforcement Administration, 2002.)

- No clear societal messages regarding harmful effects – Debates about medicinal use and legalization of marijuana cloud the issue of whether marijuana is harmful. According to the National Institute of Drug Abuse, researchers have found that chronic exposure to delta-9-tetrahydrocannabinol (TCH) is associated with impaired attention and memory, and deterioration of learned behaviors. Children exposed to marijuana prenatally demonstrate impaired verbal reasoning and memory. Scientists have also found signs of lung tissue injury and destruction in individuals who smoke marijuana regularly. (National Institute of Drug Abuse, “Facts about Marijuana and Marijuana Abuse.” *NIDA Notes Tearoff*, Vol. 11, No. 2, March/April 1996, p.2.)

### **Clarification of Laws Regulating Access to and Use of Marijuana.**

#### **A. Medical Marijuana**

In 1998, Washington voters approved Initiative 692 (RCW69.51A) allowing people who suffer from specific medical conditions to use marijuana if approved by their physician. Under RCW 69.51A, the Washington State Medical Quality Assurance Commission has the responsibility to review petitions to approve or reject the addition of "terminal and debilitating medical conditions" not originally included in the law for use of medical marijuana. In defining standards for what diseases could qualify as "terminal and debilitating medical conditions" the Commission has determined that diseases which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms and spasticity, when these symptoms are unrelieved by standard medical treatments and medications may be considered for approval for use of medical marijuana. (RCW 69.51A005, and Medical Quality Assurance Commission, 1999.)

Several issues that existed at the time of passage of the initiative still have not been addressed. These include:

- Federal law does not allow possession, distribution, or production of marijuana, except as exemptions are granted for research purposes. This includes Federal Drug-Free Workplace laws that prohibit use of illegal drugs in the workplace.
- State law only allows support of marijuana via patient-grown marijuana.
- Current law does not define what constitutes a 60-day supply of marijuana.
- Enforcement is inconsistent due to ambiguities in the law. The law on medical marijuana has a number of ambiguities. Legislative action will be required if these ambiguities are to be clarified–
  - Washington State residents who use marijuana for medical purposes, health care providers, and law enforcement agencies acting in compliance with Washington

*As currently written,  
Washington State's law on use  
of marijuana for medical  
purposes needs amendment.*

State law could be found in violation of federal law which does not allow for the use of marijuana.

- Patients with written approval from their physicians to use marijuana as part of their medical treatment can legally possess a 60-day supply. However, no legal standard for what constitutes a 60-day supply has been developed.
- Although an individual may possess written authorization from their physician to use marijuana for medical purposes, it is still illegal to purchase marijuana or to grow it for others. Possession of a 60-day supply for individuals with written physician approval to use medical marijuana is generally interpreted to include marijuana grown by the patient, but there is no standard to assist either the patient or law enforcement with defining what constitutes a 60-day supply. (Washington State Governor's Council on Substance Abuse, 2000.)
- Implementation of the medical marijuana law has created a mixed message regarding use of marijuana by youth; it is legal for some people, but illegal for them.

## B. Drug Paraphernalia Law

It is not uncommon to walk into a convenience or other retail store in many Washington communities and find drug paraphernalia openly displayed. In 1981, RCW 69.50.102 was revised to define “drug paraphernalia” and the penalties for possession and sales of drug paraphernalia. This statute makes it illegal to possess or sell products that are “intended for use or designed for use in ingesting, inhaling, or otherwise introducing marijuana, cocaine, hashish, or hashish oil into the body.”

Since 1981, the enforcement of the drug paraphernalia law has been inconsistent from one jurisdiction to the next. This may be in part because there has been little emphasis to educate local law enforcement agencies about the existence or enforcement of this law. More recently, the decline in local governments' revenues following the passage of Initiative 695 has strained local governments' budgets. With fewer financial resources, local law enforcement agencies, prosecutors and courts must often prioritize which enforcement efforts to emphasize.

The Liquor Control Board's Liquor and Tobacco Enforcement Agents are charged with enforcement of laws related to the sale of tobacco and alcoholic beverages. In carrying out their duties, they are routinely in the same retail stores that have become prime locations for the sale of drug paraphernalia. One possibility for better enforcement of RCW 69.50.102 is

to extend the authority of the Liquor and Tobacco Enforcement Agents to include enforcement of violations related to the sale and possession of drug paraphernalia.



*Open display and sale of drug paraphernalia in Washington's retail stores sends a mixed message about drug use.*

Continuing to allow the open display and sale of drug paraphernalia sends a mixed message about the use of marijuana and other drugs. The use or possession of illegal drugs is prohibited. At the same time drug paraphernalia is openly sold, for use with “tobacco” products, even though it's clear that these products are intended for use with illegal drugs.

## **RECOMMENDATIONS**

### **1. Increase Knowledge of the Risks for the Use of Marijuana**

The Governor's Council on Substance Abuse recommends that the Governor accepts and implements the Washington State Prevention Plan as official state policy for substance abuse prevention to include:

- A statewide focus of substance abuse prevention programs on reducing the levels of use of alcohol, tobacco, and other drugs, including marijuana. This would be accomplished through local prevention planners focusing services for specific populations or geographic areas. Local prevention planners would use research-based practices and guiding principles in selection, design, and implementation of prevention programming.
- A collaborative emphasis for state and local prevention providers to ensure a comprehensive, continuum of services for individual, families, schools, and communities based on locally identified drug abuse prevention needs. These collaborative efforts will reduce duplication of services and increase coordinated efforts.

### **2. Clarify and Enforce Laws Related to the Access and Use of Marijuana**

#### **A. Medical Marijuana**

The Governor's Council on Substance Abuse recommends that the Legislature—

- 1) Implement rule-making to resolve the ambiguities in the law including:
  - Defining a "60-day supply" of medical Marijuana.
  - Defining the means intended for identification of legitimate users and caregivers by law enforcement.
- 2) Explore the conflict between federal drug-free workplace laws and the medical marijuana initiative—
  - Ask the Attorney General for a legal opinion concerning the medical use of marijuana by an employee working for an employer governed by Federal workplace laws.

#### **B. Enforcement of Drug Paraphernalia Law**

The Governor's Council on Substance Abuse recommends the following action to improve enforcement of RCW 69.50.102:

- 1) The Council recommends that RCW 66.44.010 (4) be amended to provide Liquor and Tobacco Enforcement Agents the authority to enforce violations of RCW 69.50.412

- (2) relating to the prohibited sale and possession of drug paraphernalia (as defined in RCW 69.50.102) in the normal course of their duties.
- 2) The Council recommends that education and training efforts provided through the Washington Association of Sheriffs and Police Chiefs, and the Liquor Control Board's Community Policing Program include specific training on the drug paraphernalia law.

## VII. ELIMINATION OF SECONDHAND SMOKE

### Priority Statement

Elimination of secondhand smoke is critical in the fight against tobacco related illness. Specific populations, such as children and workers in some settings and industries, are in need of increased levels of protection. Likewise, emphasis on highly effective strategies such as well-focused public education efforts and elimination of local preemption of tobacco laws, are also needed.

### Key Policy Questions Addressed

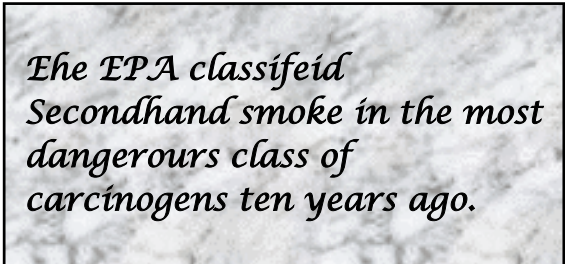
- To what extent is secondhand smoke a serious health threat to the people of Washington State?
- Why are specific populations at greater risk to the consequences of secondhand smoke?
- What role can state and local government play in eliminating secondhand smoke?
- Have best practices or proven strategies for the elimination of secondhand smoke been established? If so what are they?
- What would facilitate the reduction of secondhand smoke here in Washington State?
- Is there public support for state and local government's involvement in the elimination of secondhand smoke?

### Issue Summary

Smoke emitted from burning cigarettes, pipes and cigars, and smoke exhaled by smokers has several names including secondhand smoke, environmental tobacco smoke, side stream smoke, and passive smoke. Regardless of what it is called it can have deadly effects on the health of nonsmokers who are subjected to it for extended periods of time.

Tobacco smoke in the environment presents a significant health risk because it contains toxic air contaminants such as acrylonitrile, benzene, styrene, aldehyde, 1 and 3-butadiene, cresols, N-nitrosamines, phenols, acetaldehyde, formaldehyde, ethyl acrylate and xylenes, some of which are confirmed or suspected human carcinogens. There is a growing body of scientific evidence to support that secondhand smoke increases risks of many diseases.

- In 1991, the National Institute of Occupational Safety and Health, Center for Disease Control, issued the report "Environmental Tobacco Smoke in the Workplace", which concluded that secondhand smoke can cause lung cancer and other health problems. (National Institute for Occupational Safety and Health, 1991.)



*The EPA classified  
Secondhand smoke in the most  
dangerous class of  
carcinogens ten years ago.*

- In 1992, the Environmental Protection Agency (EPA) classified secondhand smoke as a “Class A” carcinogen, the most dangerous class of carcinogens. The agency’s final report “Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders”, concludes that secondhand smoke is a human lung carcinogen responsible for some 3,000 deaths annually from lung cancer among non-smokers. (Environmental Protection Agency, 1992.)
- In 1996, the CDC reported in the Journal of the American Medical Associations, that 9 out of 10 non-smoking Americans have been subjected to significant exposure to secondhand smoke. A study showed measurable levels of cotinine in the blood of 88 percent of all non-tobacco users. (Pirkle, et. al., 1996.)

At greatest risk for exposure to secondhand smoke are infants and young children. Youngsters do not have the ability to voice opposition to smoke filled environments. Parents and caregivers are often unaware of the damage being inflicted as the result of frequently exposing children to tobacco smoke. Secondhand smoke is especially dangerous for children because their bodies are still developing and highly susceptible to the toxins in tobacco smoke. Exposure to the chemicals and harmful agents in smoke puts children at severe risk of respiratory diseases and can hinder the growth of their lungs. Effects can last a lifetime.

*Secondhand smoke can have deadly effects, especially for children.*

In theory, office work environments, retail establishments and public buildings are free of smoke in Washington State. However, current laws and regulations do not prohibit smoking in many non-office worksites. Restaurants, bars, bowling alleys, bingo halls, taverns, manufacturing and industrial sites are examples of places that are exempted from clean indoor air regulation. Workers and the public can be exposed for long periods of time to secondhand smoke in these settings.

*Currently, Washington State's overall protections are inadequate. For example, state law does not protect workers and the public in many non-office worksites.*

Washington State government has a long-standing role in addressing the health effects of secondhand smoke. In past years Washington has taken three major policy steps to limit the health effects of secondhand smoke. First, in 1985, the Washington Clean Indoor Air act (RCW 70.16) was passed. This act specifies that smoking is not permitted in public places, except in designated smoking areas. Certain public areas may not be designated as smoking areas. These areas include: elevators; buses (except for private hire); streetcars; taxis (except those clearly and visibly designated by the owner to permit smoking); public areas of retail stores and lobbies of financial institutions; office reception areas and waiting rooms of any building owned or leased by the state of Washington or by any city, county, or other municipality within Washington; museums; public meetings or hearings; classrooms and lecture halls of schools, colleges, universities; lobbies, seating areas and aisle ways of concert halls, theaters, auditoriums, exhibition halls and health care facilities (except nursing homes).

Second, in 1989, an Executive Order by the Governor established a no smoking policy within state facilities. This mandate also specifies that state agencies provide appropriate assistance to employees requesting help with smoking cessation.

And third, in 1994, the Department of Labor and Industries passed workplace air regulations. These regulations prohibit smoking in office work environments but include additional provisions for enclosed smoking rooms that satisfy specific criteria with regard to ventilation, cleaning and maintenance, and clear designation as a smoking room.

While the policies described above are in effect here in Washington, overall protections are inadequate. As noted, there are work environments not under the jurisdiction of the Clean Indoor Air Act, the Governor's Executive Order, or workplace air regulations or, as described above, many workplaces are specifically exempted from regulation. Unfortunately, many people are still involuntarily exposed to environmental tobacco smoke where they live, work or seek recreation. New additional steps need to be undertaken to further safeguard residents of Washington from the clear dangers posed by environmental tobacco smoke.

The scientific literature is replete with strategies to eliminate secondhand smoke from many indoor locations. Leading efforts include public education regarding the dangers of secondhand smoke in places such as restaurants; targeted education for parents and child care providers; and stricter enforcement of clean indoor air regulations; and allowing local governments to establish stricter indoor smoking bans than are set by the state.

According to recent reports the effectiveness of these strategies varies depending on approach and methods used. Current studies indicate that the most effective strategy is the elimination of preemptive controls at the local level. Elimination of overt or implied local preemption gives local boards of health, county commissions, city councils and other local leaders the power to legislate local ordinances that can be far stronger and community specific than those established at the state level.

*Local ordinances carry significant weight in eliminating indoor tobacco smoke. Restricting laws to the state level (preemption) is a tobacco industry strategy, so the industry can more easily influence the policy process. To date, Washington has not been successful in eliminating preemption despite repeated tries. Local jurisdictions cannot enact policies more restrictive than those enacted by state government.*

Preemption is a tobacco industry strategy used to control tobacco prevention efforts. By restricting laws to the state level the industry can much more easily influence the political process in their favor. Local implementation of rules and laws would ensure not only a multiplicity of activities and approaches but also far more effective, community-driven solutions that address the problem more effectively than a stand-alone state approach.

A significant body of literature shows conclusively that when it comes to tobacco control, local ordinances carry significant weight in eliminating indoor tobacco smoke. Reducing exposure to secondhand smoke and removing it from the public eye is a social step that acts to change public perception, particularly among youth who often are under the impression that “most” people smoke. Without preemption, communities are able to create and implement community-specific solutions via policy and regulation that can effectively counter the media message of widespread tobacco use as an acceptable reality. If the general public, particularly youth, are not consistently seeing and experiencing secondhand smoke, prevention messages can more realistically be seen and believed.

The tobacco industry strongly supports preemption. Laws that limit authority at the local level have been implemented in about a quarter of the states. These measures are hard to repeal. A recent study published in the Journal of the American Medical Association (JAMA) reported that of six states attempting to repeal their preemption laws only one state was successful. (Hobart, 2002.) Washington has not been successful in eliminating local preemption although repeated efforts have been made.

The same JAMA article reported that the vast majority of the public supports local control of public health problems and believes that local government should have the ability to protect its citizens from the hazards associated with tobacco smoke. Likewise, the National Cancer Institute has reported that a clear majority of adults thought smoking should be strictly prohibited in places where people conduct personal or public business, such as offices, hospitals, and shopping malls. Tolerance for smoking was relatively high in cocktail lounges and bars; however, even in this setting 45 percent of adults favored some smoking restrictions and 24 percent thought smoking should be strictly prohibited.

## **RECOMMENDATIONS**

### **1. Eliminate Secondhand Smoke Exposure for Children.**

- Policy Action Strategy: Continue support for efforts currently underway by the Washington Department of Health’s Tobacco Prevention and Control Program and its local partners to educate the general public and parents and caregivers regarding the dangers of secondhand smoke to infants and young children. Funding for Washington State’s tobacco plan should be at or above the CDC recommended minimum of \$26.24.
- Healthy People 2010 Goal 27-9: Reduce the proportion of children who are regularly exposed to tobacco smoke at home, so that no more than 10 percent of children are exposed four or more days per week.
- Washington Measure: 15.7 percent of adults reported that someone had smoked inside their home on one or more of the past 30 days. (Fall 2000 adult telephone survey.) Among 6th graders, 38 percent reported being in a room with someone who was smoking, and 37.9 percent reported riding in a car with someone who was smoking, at least once during the past week. (Washington State Survey of Adolescent Health Behavior, 2000.)

**2. Eliminate Implied or Overt Preemption to Washington State Laws to Allow Local Jurisdictions to Enact Environmental Tobacco Smoke Restrictions Stronger than Those at the State Level.**

- Policy Action Strategy: Develop and implement legislation that eliminates preemption.
- Healthy People 2010 Goal 27-19: Eliminate laws that preempt stronger tobacco control laws.
- Washington Measure: Washington has preemption restrictions in place throughout the state to prevent local jurisdictions from enacting measure that are more restrictive than or vary from state law. Due to preemption, no local jurisdictions in Washington have regulations against smoking in public places. Kitsap County, Marysville and Granite Falls have volunteer policies restricting smoking in public parks. Puyallup is attempting a similar measure.

**3. Eliminate Secondhand Smoke Exposure in the Workplace.**

- Policy Action Strategy: Continue to support smoking bans in work place settings. Develop and implement legislation to expand smoke free work site laws to include all places of employment in Washington State.
- Health People 2010 Goal 27-12: Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas, so that by 2010, 100 percent of work sites have such policies.
- Washington Measure: 29.6 percent of Washington adults report that they are exposed to secondhand smoke for one or more hours per week while at work. (Fall 2000 adult telephone survey.)

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## VIII. MULTI-JURISDICTIONAL NARCOTICS TASK FORCES AS ONE STRATEGY FOR DECREASING DRUG TRAFFICKING IN WASHINGTON STATE

### Priority Statement

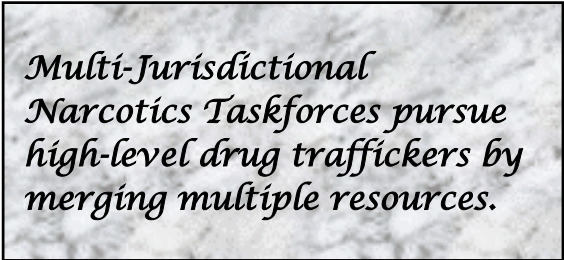
Maintain support for the Multi-Jurisdictional Narcotics Task Forces as one strategy to decrease drug trafficking in Washington State.

### Key Policy Questions

- Do the current policies and program strategies for the statewide reduction of drug trafficking work and why?
- Is the current level of Byrne Grant funding sufficient for what the Multi-Jurisdictional Narcotics Task Forces are required to do?
- With reduced federal Byrne Grant and local government funding for taskforces, how can we insure that there will be an adequate system to decrease drug trafficking in Washington State?
- How can the state help local governments maintain adequate drug trafficking reduction services?
- How should Washington State respond to requests to fund additional taskforces?

### History and Description of Model

The majority of the ongoing multi-jurisdictional narcotics task forces in Washington State were formed between 1987 and 1993. Their purpose was to address the rapid rise in drug trafficking and related crime, targeting both street level and higher-level traffickers. Starting in 1991, the focus the taskforces shifted from the local street level dealers most visible to the general public to the drug offenders who operate at levels above the ability of most local police agencies to adequately investigate. By merging the personnel, equipment and fiscal resources of multiple local law enforcement agencies, multi-jurisdictional narcotics task forces have created the ability to pursue high-level drug traffickers. One major advantage is that with combined resources and active inter-agency cooperation, taskforces can also investigate and arrest offenders without regard to the local jurisdictional boundaries. These boundaries often had hampered single agency investigations before the taskforces were formed.



*Multi-Jurisdictional  
Narcotics Taskforces pursue  
high-level drug traffickers by  
merging multiple resources.*

Initially ten task forces were funded, and an additional eleven were added as soon as federal funding became available. One of the original 21 taskforces has folded due to the lack of

sufficient commissioned officers to provide both basic patrol and specialized enforcement services.

There are currently 20 regional narcotics task forces that receive federal Byrne grant funding through contracts with the Washington State Community, Trade and Economic Development (CTED). CTED also contracts with the Washington State Patrol (WSP) to provide trained narcotics investigation support for taskforces that request it. The WSP provides investigators or supervisors to nine of the taskforces utilizing federal grant funds and six utilizing state funds. An additional WSP officer will be assigned to another taskforce in July 2000. Additional assignment of WSP personnel to taskforces is limited by WSP's lack of funding for non-patrol personnel assignments.

The 20 task forces receiving Byrne funding are comprised of 71 local law enforcement agencies, two tribal police departments, the WSP, and representatives of several federal agencies. The 20 task forces actively cover 32 of Washington's counties. Seattle, Tacoma, and Yakima County also have drug taskforces that do not receive federal Byrne grant funds. Collectively, the taskforces serve more than 95 percent of the state's population. While the taskforces currently cover the majority of Washington State, there are currently 7 counties that do not participate in or receive services from a multi-jurisdictional narcotics task force. A few small counties remain unserved either because they lack sufficient police officers to provide both basic patrol services and assign officers to a regional task force, or because Byrne grant funds are insufficient to expand the number of taskforces beyond those already funded.

*Multi-Jurisdictional  
Narcotics Taskforces  
currently serve 95 percent of  
Washington's population, but  
seven counties do not receive  
services from a multi-  
jurisdictional entity.*

To work effectively across jurisdictions, the multi-jurisdictional model currently in place in Washington State must have personnel committed by multiple, member agencies as well as funding from multiple sources. The basic taskforce model requires a minimum of four investigators, a supervisor, support staff and prosecutorial support. All of the 20 current task forces meet this minimum staffing requirement. More than half of the taskforces have full time dedicated prosecutors. Those taskforces operating without full time prosecutors receive sufficient prosecutorial support from their member counties to handle the taskforce generated caseload.

Adoption of an intelligence system common to law enforcement beyond this state's task force program is essential for intelligence gathering activities. To meet this need, all 20 task forces have adopted the Regional Information Sharing System (RISSNET) operated by the Western States Information Network (WSIN) that is operative throughout the western United States.

## Importance of Multi-Jurisdictional Narcotics Taskforces

Currently the Multi-jurisdictional Narcotics Task Force Program is the major law enforcement mechanism for pursuing the category of offenders between street level dealers and their immediate suppliers, and those organizations targeted by federal agencies. The Multi-jurisdictional Narcotics Task Forces provide half of all the drug-dedicated law enforcement officers in the state, and virtually all of the dedicated drug enforcement officers in rural areas. Although the support for

local law enforcement has traditionally been viewed as a local government responsibility, local law enforcement agencies are unable to adequately address cross-jurisdictional and statewide drug trafficking problems without this multi-jurisdictional support.

*Washington State's Multi-Jurisdictional Narcotics Taskforces achieve a conviction rate of 96 percent, compared to a national level of 52 percent.*

- Washington State's 20 multi-jurisdictional narcotics taskforces have achieved a conviction rate of 96 percent, compared to a national conviction rate of 52 percent.
- Under federal Byrne grant requirements, taskforces are required to achieve a 20 percent arrest rate for mid to upper-level drug traffickers. Washington taskforces have achieved up to a 57 percent arrest rate for mid to upper-level traffickers, and routinely achieve arrest rates for over 40 percent of these cases.
- Over 65 percent of the drug enforcement awareness and investigation training provided for local police departments is provided by the multi-jurisdictional narcotics taskforces.

## Impact of Reductions in Federal and Other Funding Resources for Drug Taskforces

Local governments provide the local funds to match the Federal Byrne funds that currently support narcotics enforcement above the street level dealers. Recent reductions in local government funds, revenue reductions from Initiative 695, and the economic recession are making it increasingly difficult for local governments to continue their funding support for their local narcotics taskforces. Another unknown is what impact the current federal shifts to an emphasis on homeland security may have on the future availability of federal funds allocated for drug trafficking reduction.

*Reductions in local government funds make supporting the taskforces increasingly difficult.*

The staff from the Office of Community Development who manage the Byrne grant will work this year with the staff and members of the Washington Association of Sheriffs and Police Chiefs to review the current Byrne funding formula and the taskforce model currently in place in Washington State. Key to this discussion will be how to avoid diminishing the gains that

taskforces have made while still addressing the varying rates of substance abuse, crime, drug trafficking, population density, and resources available in different parts of Washington State. Recommendations from this group will be presented to the Department of Community, Trade and Economic Development for their use in the development of future Byrne Grant budgets.

### **Data Collection, Intelligence, and Reporting**

The Byrne Reporting System (BRS) database system developed by Office of Community Development staff has replaced the Washington State Patrol's outdated Advanced Revelation software (AREV) for tracking narcotics taskforce data. By the end of SFY 2002, the BRS data will provide both individual task force and statewide analysis.

In the near future the BRS data will be used with several other statewide databases to create a comprehensive database that can be used for state and county level comparative crime analysis.

#### Outcome Measures vs. Performance Measures:

The lack of appropriate outcome measures for law enforcement programs of this type has become a national issue as well as a local program issue. All performance measures to date are best described as impact and effectiveness measures. Two major obstacles to using outcome measures are:

- Approximately one-third of the task forces are operating at minimal staffing/funding levels. Implementation of strict performance measures without additional funds could drive some task forces out of business. This would further jeopardize Washington State's ability to provide an adequate system for drug trafficking reduction.
- The statistical correlation between social indicator data such as treatment demand, drug-related deaths, and other social and economic costs crime data has not yet been extensively researched. Correlation of crime and social indicator data may document what changes are occurring, but it may not be possible to determine a direct causal relationship that can be used to evaluate the effectiveness of current law enforcement strategies, or to use as a basis for implementing new law enforcement initiatives.

#### Resources to Respond to Social Service Needs Identified by Task Forces

The task forces have routinely found children present at both marijuana grows and meth labs. Law enforcement agents seizing illicit meth labs across Washington State during 2001 found a total of 175 children at drug lab locations (out of 939 labs seized), with an average age of 7½ years. One hundred eleven (63 percent) of these children were referred to Child Protective Services. At 80 sites, children evidenced chemical exposure. (Northwest High Intensity Drug Trafficking Area, May 24, 2002.)

*Taskforce members routinely find children present at both marijuana grows and meth labs. Social services often lack the resources necessary to respond with the taskforce.*

- At marijuana grows, task forces have repeatedly had to forego immediate arrest of all the parties of the operation in order to provide for continual supervision of the children present.
- At methamphetamine production sites the task forces have been instrumental in charging the operators with child endangerment and removing the children from parental control.

In both situations social services often lack the resources to respond with the task force, forcing the police into actions, which are normally considered an inappropriate use of their resources. In addition, it appears that there is little direction as to how the CPS worker is to determine if substance abuse is a contributing factor in child abuse and neglect. This leaves the worker with little guidance and a wide range of subjective discretion for making this determination. The majority of children living with methamphetamine-addicted parents are the victims of child abuse or neglect and will need the protection of the child welfare system. Most of these children end up in foster care. (Washington State Governor's Council on Substance Abuse, 2002.)

### **Funding Threats**

- The Federal Byrne grant funds available to Washington State decreased this year (July 2002-June 2003 – SFY'03) by \$129,895 as the result of national population shifts in the latest census.
- With the elimination of state funds to provide backfill for funding losses to local governments after passages of Initiative 695, many local governments will have difficulty maintaining their current level of match funds for Byrne grant funds received for local taskforces.
- In 2002, the State of Washington passed legislation that complies with the national sex offender registration non-compliance provisions. This saved the state from a potential loss of \$1 million in Byrne funds annually. However, there are additional federal sex offender compliance requirements for SFY '04 that may again jeopardize 10 percent of the state's Byrne grant allocation.
- There are several different proposals under discussion at the federal level for the restructuring federal criminal justice assistance to the states. All proposals would combine a number of federal justice programs, including Byrne. The President's proposal would combine a set of separate justice programs currently funded at \$1.3 Billion into a \$800 Million block grant. Other proposals under discussion in Congress and at the Bureau of Justice Administration combine different sets of justice programs with varying degrees of financial impact to states. It will be at least late fall of 2002 before the final decision is made.

## **RECOMMENDATIONS**

The Governor's Council on Substance Abuse recommends that the Byrne Grant management staff from the Office of Community Development work cooperatively with a taskforce workgroup of the staff and members of the Washington Association of Sheriffs and Police Chiefs—

- 1. To review the current Byrne funding formula and the taskforce model currently in place in Washington State.**
- 2. Research how to solve funding and geographic coverage issues without diminishing the gains that taskforces have made while still addressing the varying rates of substance abuse, crime, drug trafficking, population density, and resources available in different parts of Washington State.**
- 3. Provide recommendations to the Department of Community, Trade and Economic Development for use in developing Byrne Grant budget proposals to the Governor.**

## **APPENDIX A SOURCES CITED**

B.L. Baxter, and J. Stevenson, *Changes in Clients' Alcohol/Other Drug Use and Lifestyles During Publicly-Supported Chemical Dependency Treatment in Washington State: October 1996-September 1997 Discharges*, University of Washington Alcohol and Drug Abuse Institute, Seattle, WA, 1998.

R. Brandon, *Policies to Assist At-Risk or Runaway, Chemically Dependent Youth*, Human Services Policy Center, University of Washington, Seattle, WA, 1999.

M. Carney, and D. Donovan, *Fact Sheet: Washington State Outcomes Project. Clinical Improvements from the Adult Residential Treatment System 6 Months Post Discharge*, Division of Alcohol and Substance Abuse, Department of Social and Health Services, Olympia, WA, 2000.

CASA, Columbia University, 1999.

L. Cawthon, *Substance Use During Pregnancy: Prevalence, Effects, and Costs*, Office of Research and Data Analysis, Washington State Department of Social and Health Services, Olympia, WA, 1997.

L. Cawthon, *First Steps Database. Substance Abuse in Pregnancy*, Office of Research and Data Analysis, Department of Social and Health Services Olympia, WA, 1993.

L. Cawthon, and L. Schragar, *First Steps Database. Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State*, Office of Research and Data Analysis, Department of Social and Health Services Olympia, WA, 1995.

Phillip J. Cook, and Micheal J. Moore, "The Economics of Alcohol Abuse and Alcohol-Control Policies," *Health Affairs*, Mar/April 2002.

Drug Enforcement Administration, 2002.

El Paso Intelligence Center (EPIC), "Seizure by State: 1/01/2001 to 12/31/2001," *National Clandestine Laboratory Seizure System*, May 30, 2002.

D.J. English, J.C. Graham, S.C. Brummel, and L.K. Coghlan, Final Report - *Factors That Influence the Decision Not to Substantiate a CPS Referral Phase I: Narrative and Empirical Analysis* (March 2002) Grant number 90-CA-1590, Department of Health and Human Services Administration for Children and Families, Children's Bureau, Office of Child Abuse and Neglect Clearing House: Washington D.C. CA/DCFS CPS Intake Referral Statistics, Jan-Dec. 2001, Refann2

Environmental Protection Agency, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*, Final Report, 1992.

S. Estee, and D. Nordlund, *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2001 Progress Report*, Office of Research and Data Analysis, Department of Social and Health Services, Olympia, WA, 2001.

Governor's Juvenile Justice Advisory Committee, *2001 Juvenile Justice Report*.

B.E. Grant, and D.A. Dawson, "Age of Onset of Alcohol Use An Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiological Survey," *Journal of Substance Abuse*, 9:103-110, 1997.

R. Hobart, *Pre-emption: Taking the Local out of Tobacco Control*, American Medical Association/Robert Wood Johnson Smokeless States, 2002.

E. Kohlenberg, D. Nordlund, A. Lowin, and B. Treichler, *Alcohol and Substance use Among Adolescents in Foster Care in Washington State: Results from the 1998-1999 Adolescent Foster Care Survey*, Office of Research and Data Analysis, Washington State Department of Social and Health Services Olympia, WA.

B. Luchansky, M. Brown, D. Longhi, K. Stark, and A. Krupski, "Chemical Dependency Treatment and Employment Outcomes: Results from the 'ADATSA' Program in Washington State," *Drug and Alcohol Dependence*, p. 60, pp. 151-159, 2000.

B. Luchansky, L. He, and D. Longhi, *Substance Abuse Treatment and Arrests: Analyses from Washington State*, Office of Research and Data Analysis, Department of Social and Health Services, Olympia, WA, 2002.

Mandell, Dorothy J. et.al. "The Impact of Substance Use and Violence/Delinquency on Academic Achievement for Groups of Middle and High School Students in Washington." (Summary). A Washington Kids Count report. Human Services Policy Center, University of Washington, Seattle, WA: 2002, 1.

C. Maynard, and G. Cox, *Evaluation of Pioneer Center North-Fact Sheet*, University of Washington, Alcohol and Drug Abuse Institute, Seattle, WA, 1999.

National Institute for Occupational Safety and Health, 1991.

National Institute of Justice, *ADAM Preliminary 2000 Findings on Drug Use and Drug Markets: Adult Male Arrestees*, December 2001, NCJ 189101, Washington D.C., Office of Justice Programs, p. 45, [http://www.adam-nij.net/files/2000\\_Preliminary\\_Findings.pdf](http://www.adam-nij.net/files/2000_Preliminary_Findings.pdf).

National Institute on Drug Abuse, "Facts about Marijuana and Marijuana Abuse." *NIDA Notes Tearoff*, Vol. 11, No. 2, March/April 1996, p. 2,  
[www.drugabuse.gov/NIDA\\_Notes/NNVoll11N2/MarijuanaTearoff.html](http://www.drugabuse.gov/NIDA_Notes/NNVoll11N2/MarijuanaTearoff.html)

New Standard, Inc., *Washington State Division of Alcohol and Substance Abuse one-Year and 18-Month Adolescent Outcomes Report*, Division of Alcohol and Substance Abuse, Department of Social and Health Services Olympia, WA, 1997.

Northwest High Intensity Drug Trafficking Area, Count from Western States Information Network data, Personal communication, May 24, 2002.

Northwest High Intensity Drug Trafficking Area, *Draft Northwest HIDTA Threat Assessment 2002*.

Office of Governor Gary Locke, "Locke Announces Drug Abuse Prevention Grants." February 26, 1999, <http://www.governor.wa.gov/press/press-view.asp?pressRelease=370&newsType=1>

Office of National Drug Control Policy, *2002 National Drug Control Strategy*, <http://www.whitehousedrugpolicy.gov/publications/policy/03ndcs/index.html>

Office of National Drug Control Policy, *State of Washington: Profile of Drug Indicators*, April 2002. Rockville, MD, Drug Policy Information Clearinghouse, <http://www.whitehousedrugpolicy.gov/statelocal/wa/wa.pdf>

Office of President, 2002

Office of Research and Data Analysis, Washington State Department of Social and Health Services, 2000.

Office of Research and Data Analysis, Washington State Department of Social and Health Services, 1997.

J.L. Pirkle, K.M. Flegal, J.T. Bernert, D.B. Brody, R.A. Etzel, and K.R. Maurer, "Exposure of the U.S. Population to Environmental Tobacco Smoke," *Journal of the American Medical Association*, 275: 1233-1240, 1996.

RCW 69.51A005, and Medical Quality Assurance Commission, 1999.

RMC Research Corporation, *Washington State Survey of Adolescent Health Behaviors 2000: Analytic Report*, Document 01-0025, Office of Superintendent of Public Instruction, Olympia, WA, 2001.

Report to Congress, 1999.

Susan Roe, Assistant United States Attorney and Tribal Liaison for the Western District of Washington, Personal Communication, May 16, 2002.

Kathryn Stewart, *Strategies to Reduce Underage Alcohol Use*, 1998.

Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, *Emergency Department Trends from the Drug Abuse Warning Network, Preliminary*

*Estimates January-June 2001 with Revised Estimates 1994-2000*, Rockville, MD, Office of Applied Studies, 2002, <http://www.samhsa.gov/oas/dawn/TrndED/2001/Text/trndEDtxt.PDF>

Bruce G. Taylor, *ADAM Preliminary 2000 Findings on Drug Use and Drug Markets: Adult Male Arrestees*, U.S. Department of Justice, National Institute of Justice, Washington D.C., 2001, <http://www.ncjrs.org/pdffiles1/nij/189101.pdf>

U.S. Department of Justice, *National Drug Threat Assessment 2002*, National Drug Intelligence Center, Johnstown, PA, 2001.

U.S. Department of Justice, Office of Justice Programs, *Fact Sheet: Strategic Approaches to Clandestine Drug Laboratory Enforcement*, Bureau of Justice Assistance, Washington D.C., 1999.

United States Sentencing Commission, Office of Policy Analysis, 2000 Datafile, OPAFY00, 2000, <http://www.ussc.gov/judpack/jp2000.htm>

University of Michigan, Monitoring the Future, "Table 9: Long-Term Trends in Harmfulness of Drugs as Perceived by Twelfth Graders," *Monitoring the Future Study, 2000 Data from In-School Surveys of 8th, 10th, and 12th Grade Students*, , <http://www.monitoringthefuture.org/data/01data/pr01t9.pdf>.

University of Washington, *Initial Analysis of Washington State Patrol Arrest Data, Drug Court Evaluation*, Alcohol and Drug Abuse Institute, Seattle, WA, 2000.

Washington Institute for Mental Illness Research and Training, Personal Communication from Diane Pearson, April 22, 2002.

Washington State Department of Ecology, June 2002. "Meth Incidents Reported By County 2002 YTD," *Environmental Reports Tracking System*,

Washington State Department of Ecology, May 3, 2002 "Number of Drug Labs Reported," <http://www.ecy.wa.gov/programs/spills/hottopics/druglabs/nolabs11.pdf>.

Washington State Department of Ecology, Personal Communication from Steve Hunter, May 29, 2002.

Washington State Department of Ecology, Personal Communication from John Williams, June 10, 2002.

Washington State Department of Health, 1999, [http://www.doh.wa.gov/Tobacco/Control\\_Plan/TobacSum.pdf](http://www.doh.wa.gov/Tobacco/Control_Plan/TobacSum.pdf).  
*A Tobacco Prevention and Control Plan for Washington State*,

Washington State Department of Health. Go Figure: Facts About Tobacco.  
<http://www.doh.wa.gov/Tobacco/gofig.htm>.

Washington State Department of Health, Personal Communication from Carolyn Comeau, May 30, 2002.

Washington State Department of Health. Tobacco Facts. Public Awareness and Education: Playing Their Game and Winning. January 2001: <http://www.doh.wa.gov/Tobacco/fact6.htm>

Washington State Department of Social and Health Services, Children's Administration, 2000.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, "Fact Sheet on Chemical Dependency and the Criminal Justice System," Olympia, WA, January 15, 2002.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, "Fact Sheet on Chemical Dependency Treatment Effectiveness," Olympia, WA, July 12, 2000.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999, *Profile of Substance Use and Need for Treatment Services in Washington State*, Olympia, WA, p. 5, <http://psy.utmb.edu/estimation/dasa99/report/drugmenu.htm>.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, Research and Data Analysis, Olympia, WA, December 1999.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1997. (TARGET), Treatment and Assessment Report Generating Tool,

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State: 2001 Report*, Olympia, WA, 2001.

Washington State Department of Social and Health Services, Juvenile Rehabilitation Administration, <http://www.wa.gov/dshs/jra/jra3ov.html>.

Washington State Governor's Council on HIV/AIDS and the Washington State Governor's Council on Substance Abuse Joint Workgroup, *Prevention of Blood-Borne Infections*, Olympia, WA, 2000.

Washington State Governor's Council on Substance Abuse, *Biennium Report 2003-05*, Children's Services Policy Paper, Washington's Department of Community, Trade and Economic Development, Olympia, WA, 2002.

Washington State Governor's Council on Substance Abuse, *Methamphetamine Abuse in Washington State*, Washington's Department of Community, Trade and Economic Development, Olympia, WA, 2000.

Washington State Institute for Public Policy, *“Can Drug Courts Save Money for Washington State Taxpayers?”* Washington State Institute for Public Policy, Olympia, WA, 1999.

*Washington State Liquor Control Board Annual Report*, 2001.

Washington State Survey of Adolescent Health Behavior, Office of the Superintendent of Public Instruction, Fall 2000.

Thomas M. Wickizer, *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*, Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, March 1999, vii-viii, xv.

T.M. Wickizer, K. Campbell, A. Krupski, K. Stark, "Employment Outcomes Among AFDC Recipients Treated for Substance Abuse in Washington State," *The Milbank Quarterly*, 78 (4), 585-608, 2000.

T.M. Wickizer, *The Impact of Substance Abuse Treatment on Employment Outcomes among AFDC Clients in Washington State*, Technical Assistance Publication Series #25, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville, MD, 2001.

T.M. Wickizer, K. Campbell, A. Krupski, and K. Stark, *Does Substance Abuse Treatment Improve Employment Outcomes for Welfare Recipients? Evidence from Washington State*, Olympia, WA, Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

T.M. Wickizer, J. Joesch, D. Longhi, A. Krupski, and K. Stark, *Employment Outcomes of Indigent Clients Receiving Alcohol and Drug Treatment in Washington State*, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Rockville, MD, 1997.

T.M. Wickizer, and D. Longhi, *Economic Benefits and Costs Associated with Substance Abuse Treatment Provided to Indigent Clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) Program*, Department of Social and Health Services, Division of Alcohol and Substance Abuse, Olympia, WA, 1997.

## APPENDIX B

### GCOSA PREVENTION STANDING COMMITTEE

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Organization	Agency Representative	Community Representative
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<b>Lieutenant Governor's Office</b>	Glen Dunnam <b>Co-Chair</b> Chief of Staff Olympia, WA 98504-0482 Phone: 360-786-7700 FAX: 360-786-7520 <a href="mailto:Dunnam_gl@leg.wa.gov">Dunnam_gl@leg.wa.gov</a>	
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Organization	Agency Representative	Community Representative
<b>Staff</b> <b>Washington State Community, Trade and Economic Development, Office of Community Development</b>	<p>Carol Owens, Supervisor Research, Evaluation &amp; Development Safe &amp; Drug-Free Communities Unit Olympia, WA 98504-8350 Phone: 360-725-3032 FAX: 360-586-4506 <a href="mailto:Carolow@cted.wa.gov">Carolow@cted.wa.gov</a></p> <p>Dale Grenier Research Investigator Research, Evaluation &amp; Development Safe &amp; Drug-Free Communities Unit Phone: 360-725-3039 FAX: 360-586-4506 <a href="mailto:Daleg@cted.wa.gov">Daleg@cted.wa.gov</a></p> <p>Gail Mitchell Secretary Senior Research, Evaluation &amp; Development Safe &amp; Drug-Free Communities Unit Phone: 360-725-3038 FAX: 360-586-4506 <a href="mailto:rickv@cted.wa.gov">rickv@cted.wa.gov</a></p>	

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## **APPENDIX C**

### **CULTURAL DIVERSITY**

#### **Guiding Principle for Cultural Diversity**

*The Governor's Council on Substance Abuse (GCOSA) in carrying out our mission commits to do so as a tireless advocate for the needs of ethnic and cultural communities across the state.*

The Governor's Council on Substance Abuse will:

- ✧ Strive consistently for multicultural awareness, respect, and responsiveness in the Council's own policy, procedures, structure, organization, documents, communications, outreach, decision and priority making, collaborations, and recommendations
- ✧ Require that all projects, programs, and collaborations of the Governor's Council on Substance Abuse be accountable for cultural competence and greater inclusiveness in their outreach, staffing, design, programming, community involvement, implementation, and evaluation
- ✧ Make as its priority the provision of ongoing support for state and local initiatives, programs, and projects that are reflective of the strengths and needs of the state's culturally diverse populations
- ✧ Facilitate and seek out ongoing opportunities to consider a broad spectrum of cultural perspectives and promote growing awareness and cultural competence by all its members and partners

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## **APPENDIX D**

### **GCOSA**

### **PUBLICATIONS**

- Governor's Council on Substance Abuse. *1996 Report and Recommendations to Reduce Substance Abuse in Washington State*. November 1996. Washington State Department of Community, Trade and Economic Development. Olympia, WA.
- Governor's Council on Substance Abuse. *1997 Report and Recommendations for State-Funded Research Priorities to Reduce Substance Abuse in Washington State*. November 1997. Washington State Department of Community, Trade and Economic Development. Olympia, WA.
- Governor's Council on Substance Abuse. *Update on the Status of Governor's Council on Substance Abuse 1996 Recommendations to Reduce Substance Abuse in Washington State*. November 1997. Washington State Department of Community, Trade and Economic Development. Olympia, WA.
- Governor's Council on Substance Abuse. *Governor's Council on Substance Abuse Report on 1999-2001 Priority Recommendations to Reduce Substance Abuse in Washington State*. August 1998. Washington State Department of Community, Trade and Economic Development. Olympia, WA.
- Governor's Council on Substance Abuse. *Implementation of Initiative 692 The Washington Medical Use of Marijuana Act*. January 2000. Washington State Department of Community, Trade and Economic Development. Olympia, WA.
- Governor's Council on Substance Abuse. *Access to Substance Abuse Treatment in Washington State*. January 2000. Washington State Department of Community, Trade and Economic Development. Olympia, WA.
- Governor's Council on HIV/AIDS and Governor's Council on Substance Abuse. *Prevention of Blood-Borne Infections*. February 2000. Washington State Department of Health. Olympia, WA.
- Governor's Council on Substance Abuse. *Governor's Council on Substance Abuse Report on Methamphetamine Abuse in Washington State*. May 2000. Washington State Department of Community, Trade and Economic Development. Olympia, WA.
- Governor's Council on Substance Abuse. *Governor's Council on Substance Abuse Policy Recommendations for 2001-03 Legislative Action*. August 2000. Washington State Department of Community, Trade and Economic Development. Olympia, WA.

Copies of Council reports can be obtained by calling the Washington State Alcohol/Drug Clearinghouse at 1-800-662-9111. Council reports are also available at the Washington State Library or at [www.ocd.wa.gov/dbs/pubs](http://www.ocd.wa.gov/dbs/pubs).

For more information about the Governor's Council on Substance Abuse call (360) 725-3032

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## APPENDIX E

### GCOSA MEMBERSHIP

<b>Chair</b>	<b>Vice Chair</b>	<b>Coordinator</b>
Priscilla Lisicich Ph.D Director Safe Streets Campaign	Larry Erickson Executive Director Washington Association of Sheriffs and Police Chiefs	Carol Owens Ed.D Office of Community Development, Safe and Drug- Free Communities Unit
Ida Ballasiotes, Washington State Representative	Al O'Brien, Washington State Representative	
Angelica Balderas, Community Representative	Dennis O'Neill, Manager Drug-free Workplace, The Boeing Company	
Terry Bergeson, State Superintendent of Public Instruction <i>Alternate: Denise Fitch</i>	Yvonne Rivers, Community Representative	
Dennis Braddock, Secretary Department of Social and Health Services <i>Alternate: Ken Stark, Doug Allen</i>	Mary Selecky, Secretary Department of Health <i>Alternates: Linc Weaver, Lillian Bensley</i>	
Martha Choe, Director Community, Trade & Economic Development <i>Alternate: Steve Wells</i>	Ronal Serpas, Chief Washington State Patrol <i>Alternates: Steve Jewell, Dan Davis</i>	
Milt Dennison Ed.D, Superintendent Camas School District	Val Stevens Washington State Senator	
Carolyn Hartness, Native American Representative	Cleve Thompson, Clark County Department of Community Svcs.	
Russ Hauge, Kitsap County Prosecuting Attorney	Linda Thompson, Executive Director Greater Spokane Substance Abuse Council	
Norman Johnson, Executive Director Therapeutic Health Services	Whalen, Mariann WS Department of Social and Health Services	
Joseph Lehman, Secretary Department of Corrections <i>Alternate: Patty Terry</i>	<b>Staff</b>	
Merritt D Long, Chair Liquor Control Board <i>Alternates: Rick Phillips, Letty Mendez</i>	Dale Grenier Ph.D, Research Investigator Office of Community Development	
Matt Mazzoncini, Youth Representative <i>Alternate: Katie Anderson</i>	Paul Perz, Managing Director Safe and Drug-Free Communities Unit	
Jim Moeller, Council Member Vancouver City Council	Gail Mitchell, Administrative Assistant Safe and Drug-Free Communities Unit	
Suzanne Moreau Washington State Labor Council	<b>Governor's Office</b>	
	Dick Van Wagenen	



## **GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE**

### **LONG-TERM GOALS FOR REDUCING SUBSTANCE ABUSE**

#### **PREVENTION**

1. Prevent and reduce the misuse and abuse of alcohol, tobacco, and other drugs.
2. Focus on outcome-based prevention strategies to increase the effectiveness of prevention efforts.
3. Increase the community ownership and responsibility for prevention of misuse of alcohol, tobacco, and other drugs.

#### **TREATMENT**

1. Increase access to and availability of chemical dependency treatment, as clinically necessary.
2. Reduce the negative effects of alcohol, tobacco, and other drugs.
3. Address the basic needs of people in chemical dependency treatment.

#### **LAW AND JUSTICE**

1. Increase public safety.
2. Increase the effectiveness of law and justice efforts to reduce alcohol and other drug abuse-related crimes.
3. Foster citizen involvement and support for effective law and justice efforts, including community-oriented policing.